2007

The Relationship Between Homelessness and Women's Health

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THE RELATIONSHIP BETWEEN HOMELESSNESS AND WOMEN'S HEALTH

by

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BAH, Queen's University, 2004

THESIS

Submitted to the Faculty of Social Work
in partial fulfillment of the requirements for
Master of Social Work

Wilfrid Laurier University
2007

Your file Votre référence
ISBN: 978-0-494-32282-6
Our file Notre référence
ISBN: 978-0-494-32282-6

Abstract

Women are increasingly experiencing poverty in Canada (Townson, 2000). This study seeks to gain an understanding of how women experience an extreme form of poverty – homelessness – within Kitchener, a mid-sized city located within the Waterloo Region in southern Ontario, and the relationship of this experience to health.

Employing social determinants of health (SDOH) theory, this study examines the relationship between homelessness and women's health. Using a qualitative approach, 10 individual semi-structured interviews were conducted with women who have experienced homelessness in Kitchener and one focus group was held.

This study indicates that homelessness had an all-encompassing influence on women's health. Women experienced both impeding and promoting factors influencing their access to housing, healthy food, employment, health care, income, and social support, all key social determinants of health. Also, this research suggests that there are four linked spheres in which the social determinants of health present themselves in the social environment of women who are homeless: social policy, community resources, living conditions, and social relationships. Also, it argues that a feminist orientation in conjunction with SDOH is needed in order to more fully understand why women who are homeless face forces detrimental to their health.

This study also has practical implications, as recommendations are made that address changes needed in order to promote women's health at the macro-level as well as community and individuals levels.

Acknowledgements

I am deeply grateful and incredibly lucky to have met 10 amazing women as part of this thesis project. The thesis came into being as a result of all of you sharing your time, your stories, and your insightful thoughts and opinions. You constantly reminded me why I chose this area of study and why I wanted to complete a thesis. More importantly, I have grown as a person through meeting you and learning from you. I hope that this thesis does justice to your words and experiences. Thank you.

There were many Kitchener and Waterloo community organizations, workers and activists who helped me with this project. So many people opened their doors to me, taught me about their community, and provided me with resources and suggestions. Thank you for your support and encouragement.

The Bettina Russell Memorial Fund also contributed to this research. Thank you for providing the financial contribution which allowed me to compensate the research participants and provide food for our focus group session.

I would like to also acknowledge and thank my thesis committee, Lea Caragata, Peter Dunn (Advisor) and Ginette Lafrenière. Thank you for giving of your time (especially in the summer months) and providing me with support as well as holding a critical eye to my project. It is very much appreciated.

To my family and friends – thank you so much! To my parents, thank you for your support and guidance. I would not have gotten through this without you both. To my sisters, thank you for reminding me to come up for a breath, even if it is only for a few minutes. Jason, your help and support was more than I could even ask for. Thank you for answering my questions, asking questions, providing your amazing editing skills at all hours of the night, listening to all of my complaints and encouraging me to finish.

I would particularly like to thank my mom. A few years ago, you decided to strive towards your lifelong goal, and go to university. After much work and struggle, not only did you achieve your dream and receive a degree, but you completed two of them. Your strength and determination continuously inspires me. Thank you so much for being such an amazing role model and setting a path for me.

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CHAPTER ONE

INTRODUCTION

Homelessness in Canada has been described as a national disaster (Shapcott, 2004). In fact, homelessness has been declared a national disaster by the Big City Mayors Caucus of the Federation of Canadian Municipalities. Although it is not known exactly how many people are homeless in Canada at any given time, the National Housing and Homelessness Network (2001) has estimated that a quarter of a million people will experience homelessness annually. Homelessness may seem to be more prevalent in large urban centres, where people who are visibly homeless sleep on the street. But many people experience a less publicly visible form of homelessness called 'couch surfing'; they find temporary accommodation with friends or relatives.

The 'homeless stereotype' tends to be male, living on the street in the urban core. However, our societal norms and assumptions are tested by current realities. Experiencing homelessness is increasingly becoming a reality in the lives of women. In the Waterloo Region, more than half of all residents in emergency shelters are women. Though the Region has one-third more shelter beds for women than men, women's shelters are still more frequently filled beyond capacity (Dietrich et al., 1999).

The experience of homelessness has a dramatic impact on the health of women. Women face numerous health concerns due to homelessness. Particularly concerning is the fact that women who are homeless have higher mortality rates than their housed counterparts (Cheung & Hwang, 2004). However, relying on statistics and measures in order to understand the relationship between homelessness and health poses many difficulties. Researchers face great challenges in locating women who are homeless, since

many women do not inhabit the public sphere (Kappel Ramji Consulting Group, 2002; Lenon, 2000; Ontario Women's Health Council, 2002; Radhika, 2004). Reliance on statistics also creates difficulties when trying to comprehend the relationship between homelessness and health, as it is through listening to people's experiences that we gain a nuanced understanding of their lives.

This research study aims to gain an understanding of the relationship between homelessness and health. Using qualitative research methods, it explores the lived experiences of women who have been homeless in the City of Kitchener, which is one of the cities within the Waterloo Region. It explores how women feel that homelessness has impacted their health. It also examines the social and political factors that influence their health. I will begin this chapter with this study's relevance to the field of social work, and then clarify terms and my personal motives, followed by a description of the City of Kitchener. Subsequent chapters will explore related literature, explain the methodology used in the current study, and present and discuss findings, followed by a conclusion and recommendations.

Relevance to Social Work

My research study fits with many of the tenets of the Canadian Association of Social Workers (CASW) Code of Ethics, which states that: "social workers promote social fairness and the equitable distribution of resources, and act to reduce barriers and expand choice for all persons, with special regard for those who are marginalized, disadvantaged, vulnerable, and/or have exceptional needs" (CASW, 2005, p. 5). My study is compatible with these goals and values, as it explores how the experience of homelessness affects the health of women, and seeks to gain insight into the factors

influencing the health of women who are homeless. These factors influence access to health care, as well as other social determinants of health, including housing, income, employment, food, and social supports. The study focuses on the accessibility of health-inducing resources and aims to raise awareness of their inequitable distribution in society.

Social work focuses on the empowerment of marginalized groups and individuals in society. In fact, the CASW Code of Ethics states that social work "has a particular interest in the needs and empowerment of people who are vulnerable, oppressed, and/or living in poverty" (CASW, 2005, p. 3). However, these ideals are often not realized. Instead of supporting empowerment, social work has a long history of supporting social control and the hierarchical nature of many current social service organizations means that "clients" are often undervalued (Carniol, 2000). Moreover, the nature of the helping profession is questioned by Rossiter (2001), who argues that through helping, the roles of helper and helped, powerful and vulnerable, are reinforced rather than overturned. Consequently, there is a significant gap between the official social work values of social justice and empowerment, and how social work is often practised and experienced.

Current practices in social work also reflect government policies and international forces. Internationally, as multinational corporations have become increasingly powerful, globalization has increased the gulf between the rich and the poor. International bodies such as the World Bank reinforce this disparity, by offering credits and loans to governments that cut social programs and social spending so as to create "favourable" climates for investment (Carniol, 2000). Nationally, such concerns as paying down the debt and reducing taxes often mean that social services face significant cutbacks (Carniol, 2000). Consequently, social workers face increasing social problems, but lack the

resources to adequately address them. More and more, they are forced to "paper over the cracks" by treating symptoms, while underlying social problems remain untouched (Carniol, 2000, p. 6).

Though the current state of social work is at best challenging, there is space to work for social justice and empowerment. If social workers are to work for these values effectively, we must not assume that we know what is best for individuals and communities, but rather listen and learn from people and join them in their struggles (Carniol, 2000). By doing so, we can become better attuned to the forces of inequality and expose them. My study hopes to work in this manner, by listening to the voices of women who are homeless, valuing their recommendations for change, and providing a space to bring light to their concerns. I learned from the voices of women, and hope that the readers of my study will do the same and join in the struggle to eradicate inequality.

Terms and Clarifications

Homelessness

Homelessness is a contested concept; it has no fully agreed-upon definition. Rather than defining homelessness as merely the state of lacking a house, many definitions try to address varying experiences of homelessness. Researchers, policy-makers and activists often utilize different definitions of homelessness. Therefore, it is important to explain some of the main definitions of homelessness and provide a rationale for the definition used in this study.

The United Nations (UN) (as cited in Charette, 1991, p. 1) defined homelessness for the Year of Shelter for the Homeless using the terms *absolute* and *relative homelessness*. *Absolute homelessness* refers to people who have no home at all – namely,

people living on the street or victims of natural disasters. *Relative homelessness* refers to people who have some form of housing, but which does not meet the UN's basic standards, which include the provision of:

- adequate protection from the elements
- access to safe water and sanitation
- secure tenure and personal safety
- accessibility to employment
- education
- health care

The definition espoused by the UN moves beyond a brick and mortar definition of homelessness and includes basic social standards.

The UN definition explores social concerns, which affect one's standard of living; however, other definitions of homelessness address the social aspect of this concept in a different manner. Literature on homelessness often distinguishes between a house and a home (Watson & Austerberry, 1986; Tipple & Speak, 2005). For example:

> A 'house' is generally taken to be synonymous with a dwelling or a physical structure, whereas a 'home' is not. A 'home' implies particular social relations, or activities within a physical structure, whereas a 'house' does not. The home as a social concept is strongly linked with the notion of family – the parental home, the marital home, the ancestral home. The word 'home' conjures up such images as personal warmth, comfort, stability and security, carrying a meaning beyond the simple notion of a shelter. (Watson & Austerberry, p. 8)

Therefore, the concept of homelessness is a social one, given the socially and culturally defined meaning of 'home.' It evokes the notion that a person who is homeless lacks a particular lifestyle considered socially acceptable and does not fulfill a normative social role, which may be a contributory force in the stigmatization and social exclusion that is often reported by members of the homeless population (DePastino, 2003).

For women, many definitions of homelessness do not incorporate their experiences. For instance, the concept of *street homeless* as homelessness denies the full inclusion of women, who are less likely than men to experience street homelessness. Rather, many women rely on social networks, such as friends and relatives, to provide temporary shelter, rather than sleeping in public spaces (Callaghan, Farha, & Porter, 2002; Radhika, 2004). Broader definitions of homelessness, too, can exclude the experiences of women. For instance, it is unclear whether the UN definition of homelessness would include a woman who is sleeping on a friend's couch, since she may still have access to basic standards of living (Callaghan, Farha, & Porter, 2002).

In order for definitions of homelessness to be inclusive, they must incorporate a range of experiences from the society and culture within which they exist. By including these experiences, researchers may better understand the complexities of homelessness and thus be better prepared to address this issue. The current study uses the Region of Waterloo's definition of homelessness:

> [A homeless person is] ... someone who is sleeping in indoor or outdoor public spaces, using emergency shelters, living in illegal or temporary accommodation and/or relying on family, friends or acquaintances for short-term housing (often referred to as couch surfing). A person staying for any length of time with family or friends would also be considered homeless, if they did not have their own private space and access key. (Region of Waterloo, Social Services, 2004, p. 3)

While this definition may not fully address all aspects of homelessness, it includes a wide range of experiences, rendering it quite inclusive. The definition also allows this research to be comparable and useful within the Region of Waterloo.

Health

Evans and Stoddart (1994) conceived health as existing on a continuum, with well-being at one end and disease, pain, and death on the other. The role of individuals within this spectrum is to identify their own sense of health and well-being. Such a concept is significant, since it holds that the individual can best perceive his or her own sense of illness. Furthermore, relying on measures such as morbidity and mortality (often used in health research) is greatly limited because they do not address a wide range of health symptoms and factors (Hart, 1985). It is through the inclusion of self-reporting methods that research validates the experiences of individuals and groups and enables a more nuanced understanding of health.

The current study utilized a self-report method to gain information about health. Rather than using a definition of health developed by the researcher, I asked participants to explain their own sense of health and well-being in both the past and present, in order to inform this study's understanding of health and health barriers.

Personal Motives and Perspectives

My decision to conduct this research study was influenced by many factors. Since high school I have been involved in organizations and services for people who are homeless. I have been greatly inspired by various people I have met along the way – people who have taught me about their own lives, myself, and the community where I live. It was also through these experiences that I first met community activists, whose dedication and perseverance have inspired me to pursue this area of research.

My involvement in community initiatives has also been strongly influenced by my family. In fact, the meal program with which I volunteered during high school was

located in the same neighbourhood that my father and his family frequented when they came to Canada. Remnants of the Eastern European community that once flourished in that neighbourhood can be seen today by the synagogue and church that are still standing, but most people from that community have since left. My father's family, like many others, was forced out of Poland during World War II. They lived in labour camps in Siberia and refugee camps all over the world, and some fought in the war. Most of those who survived eventually made their way to Canada. Their experiences of intense poverty and struggle have continued to inspire me and feed my pride in my family's roots. These stories have also taught me about the importance of community, as it was through their bond as a family and their connections to their community that helped my father's family make a place for themselves in Canada. Growing up with stories of these experiences has also nurtured my belief that communities should help sustain everyone living within them and has motivated me to learn more about poverty-related issues and help to find ways to eradicate them.

My belief in the importance of community has been nurtured by my own political location as a socialist. As such, I believe in community control of property, production, and the distribution of wealth. However, like Lebowitz (2007), I believe that a socialist system should not allow the state to preside over and above civil society. Rather, people should be engaged in democratic organizations at the neighbourhood and national levels, in order develop collective solutions to social concerns. My political orientation, which is focused on participation, has influenced me to develop a research project seeking the voices of those who are often not heard – women who are homeless. Through inclusion

and participation, social concerns are more thoroughly examined and appropriate solutions can be developed.

While I have chosen to research health and homelessness, I have focused particularly on women. As a woman, I feel it is important that gender inequality be recognized not only as experienced in daily life, but also through research. I sought out the experiences of women as a means by which to provide a space for women to speak about their lives and to include these voices in research. Too often, these voices are left out, which greatly inhibits a nuanced understanding of society. By learning about the experiences of women, I have learned more about myself and about the gendered nature of society.

My own position as a middle-class student completing a thesis as part of a master's degree program influenced my role in the study. I was made aware of my social position throughout the course of this research. On one occasion, I visited a local organization in order to discuss the study and waited along with service consumers for the attention of a worker. The worker ignored us, but when I introduced myself as the researcher, the worker immediately apologized for making me wait, but continued to take little notice of the people beside me. This experience prompted me to consider how I am treated differently because of my position as a master's student and how my ability to conduct this study was facilitated by this positioning. This experience also showed me that negative treatment towards those who are oppressed is quite pervasive in society, including among those whose job it is to help them. Although I have gained an understanding of these experiences through this research, I will never be able to fully understand them unless I experience them myself.

Picture of Kitchener

This section describes the geographic area and some of the socio-economic characteristics of Kitchener in order to provide a more general overview of poverty and homelessness in this area. Given that research focused solely on the Kitchener is limited, the broader region in which Kitchener is located, the Waterloo Region, is predominately described in this section.

Location and General Information

Located in Southern Ontario, the Waterloo Region has a population of almost half a million people. The Region consists of seven municipalities, including both cities and townships. Roughly 77% of the Region is rural geographically (Region of Waterloo, Social Services, 2003). Often described together, two of the cities within the Region are Kitchener and Waterloo. Waterloo is home of two universities – Wilfrid Laurier University and the University of Waterloo, as well as many high-tech firms. Kitchener is the more populous of the two cities and its economic base is primarily manufacturing (Ash, 2004).

Poverty in the Waterloo Region

In the 1980s and 1990s, the Waterloo Region, like many Canadian communities, faced economic difficulties in the form of recessions. However, the Region was able to make a considerable recovery, as new technological industries developed in the area. Yet these economic improvements were not felt and experienced equitably, since over 20% of the labour force in the Region works in low-wage, part-time jobs with few benefits (Caledon Institute of Social Policy, 1999). Furthermore, according to the 2003 Waterloo Region's Housing Needs Survey, 43% of renter households are paying more than 30% of

their income for rent, which is generally accepted as an affordability threshold (as cited in Region of Waterloo, Social Services, 2004). For those who cannot afford housing, subsidized housing may seem like a viable option; however, there are typically 4,000 households (approximately 10,000 people) on the Community Housing[1] Waiting List (Region of Waterloo, Planning, Housing and Community Services, 2005a) Therefore, despite growing wealth in the Waterloo Region, poverty is a significant feature of this community.

Homelessness in the Waterloo Region

Currently, there is a sizable population of people who are homeless in the Waterloo Region. Between 1,500 and 2,000 people in this area experience absolute homelessness annually; however, the number of people experiencing other types of homelessness has not been yet calculated. About 172 people sleep in a shelter on any given night in the Region (Dietrich, Morton-Ninomiya, Vandebelt, Adams, DeSantis, & Klassen, 1999). Community organizations and programs that address some of the aspects of homelessness have seen staggering increases in the usage of their services. For instance, one Out of the Cold[2] site in Kitchener provided overnight shelter to 1,537 people in 2004-5 – a five-fold increase from 1999-2000 (as cited in Hausfather, 2005). Clearly, homelessness not only exists in the Waterloo Region; it is increasing.

There are many reasons why people become homeless; homelessness cannot be merely reduced to not having work. In the Waterloo Region, Dietrich et al. (1999) found

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[1] Community housing refers to affordable rental housing units (includes non-profit, subsidized, rent geared-to-income, and cooperative units), which are owned by a not-for-profit organization (both community-based and government owned) (Region of Waterloo, 2005).

[2] Out of the Cold is a volunteer run-program that operates out of churches during the winter months. It provides emergency overnight shelter and typically also offers a meal to its guests.

that 14% of shelter residents were employed. The cost of maintaining housing on limited incomes has become exceedingly difficult. In fact, the Waterloo Region has asserted that affordable housing is "one of the largest challenges facing our community today" (Region of Waterloo, Planning, Housing and Community Services, 2005b, p. 1). For instance, even a single person earning minimum wage could not afford a bachelor or one bedroom apartment in this area (Region of Waterloo, Planning, Housing and Community Services, 2005b). Given an affordability threshold for housing at 30% of one's income, a single person would only have $349 for housing if they earned a minimum wage salary. However, the Canadian Mortgage and Housing Corporation's (CMHC) average market rent for a bachelor apartment in the Kitchener CMA (Census Metropolitan Area) is $517, amounting to a $168 gap (Region of Waterloo, Planning, Housing and Community Services, 2005b, p. 3). Even for those working full-time on a minimum wage salary, housing is unaffordable in the Waterloo Region. Low minimum wages, as well as the lack of affordable housing, are significant barriers to finding and maintaining housing.

Given the magnitude of homelessness in the Waterloo Region, government officials and agencies have responded to this concern. In fact, the Waterloo Regional Council identified homelessness as a significant concern in 2004 and spent $14 million dollars to address it (Region of Waterloo, Social Services, 2004).

Women, Poverty and Homelessness in the Waterloo Region

Poverty is a women's issue. Women are more likely to experience poverty than men, and they account for almost two-thirds of all minimum wage workers in Canada (Sussman & Tabi, 2004; Townson, 2000). In the Waterloo Region, this trend is evidenced by the number of women applying for community housing. Every year, for the last six

years, more women than men (co-applicants/couples not included) have applied for community housing. According to the Planning, Housing and Community Services Department of the Regional Municipality of Waterloo, from 2000 to 2005, women submitted an average of 1,248 applications for community housing in the Waterloo Region, whereas their male counterparts submitted 420 (J. Schumacher, personal communication, August 14, 2006). This considerable disparity in the number of community housing applications attests to the gendered experience of poverty in the Waterloo Region, reflecting that at the national level.

Relationship breakdown is one of the main reasons why women in the Waterloo Region seek emergency shelter. According to a report on homelessness led by the Social Planning Council of Kitchener Waterloo, almost half of all shelter residents identified some kind of relationship difficulty as the primary cause for being in a shelter (Dietrich et al., 1999). Such a large number is particularly significant for women, since women tend to experience homelessness after escaping domestic violence (Miles, 2006). Between 2002 to 2006, the Women's Crisis Services of Waterloo Region (WCSWR), which includes Haven House and Anselma House crisis shelters for abused women and their children, served an average of 280 women and 222 children per year, with a slight increase experienced over the 2004/5 to 2005/6 period (Social Planning Council of Cambridge and North Dumfries, 2006).

CHAPTER TWO

LITERATURE REVIEW

A great deal of research literature has examined the health of women who are homeless. To provide context, this section examines the literature on women and homelessness and the health of women who are homeless. It also explores the social determinants of health framework, which is the main theoretical model for the current study. The section also discusses local Waterloo Region research tackling these issues. To make this study applicable to the Canadian context, this literature review primarily focuses on Canadian research.

Women and Homelessness

There is extensive research and literature on issues related to homelessness in Canada. However, researchers face specific obstacles when they attempt to attain information about women and homelessness. These obstacles relate to homeless women's relative invisibility to researchers. Dr. Stephen Hwang (2001), a physician and research scientist at St. Michael's Hospital's Centre for Research on Inner City Health in Toronto, contends that because women who are homeless are not likely to inhabit space in the public sphere, for instance, they do not tend to sit on sidewalks as much as homeless men do, they also tend to be absent from the public consciousness and discourse. Consequently, researchers tend to study them less than men (Radhika, 2004). Women are still more likely than men to use alternative forms of shelter, such as staying with relatives and friends, also called 'couch surfing', rather than using the shelter system (Kappel Ramji Consulting Group, 2002; Lenon, 2000), although this is changing. Furthermore, the Ontario Women's Health Council (2002) report, *The Health Status of*

Homeless Women: An Inventory of Issues, found that women's different experience of homelessness has impacted homelessness statistics. Since these statistics are based to a large extent on data collected from shelters, which women are less likely to use, they underestimate the extent of women's homelessness. Therefore, the tendency of women who are homeless to rely on social networks for shelter has limited their representation in research. Consequently, researchers must avoid focusing primarily on the forms of homelessness typically experienced by men, when conducting research. Rather, they must actively seek out the experiences of women, allowing women to express their realities and experiences.

There are difficulties associated with studying issues related to women and homelessness, but such research is increasingly being undertaken in major Canadian centres, as well as on a national scale. Although these studies are likely to underestimate the number of women who are homeless, they still indicate that increasingly large numbers of women are experiencing homelessness. The City of Toronto's 1999 report, *Taking Responsibility for Homelessness*, by the Mayor's Homelessness Task Force, noted that single women and women with children together make up 29% of shelter users in this city. Notably, over the period 1992–1998, there was a 78% increase in shelter use among single women (City of Toronto, 1999). These findings do not reflect only the situation in the City of Toronto; rather, they echo a national trend of women's growing poverty. For instance, Monica Townson's (2000) report, *A Report Card on Women and Poverty*, comments on the specific trends towards women's increasing poverty in Canada and notes that women are increasingly becoming poor. This report is guided by the concept, "the feminization of poverty," which captures the fact that women are

increasingly experiencing poverty at a higher rate than men. Indeed, the poverty rate for women has increased dramatically in recent years. In 1990, 1.8 million women in Canada had low incomes. Only 10 years later, this number climbed to 2.2 million (Townson, 2000). Given the distinct increase in women's poverty and homelessness and the under-representation of women who are homeless in research, studies should focus on women's experiences of homelessness in order to better understand this significant trend and the impact it is having on women's lives.

Diversity within Experiences with Homelessness

Women are overrepresented in poverty; however, women do not constitute a homogenous group. Their diversity is reflected in differing experiences with homelessness. Women who are homeless encompass numerous sub-groups based on such factors as age, ethnicity, race, ability, and disability (Ontario Women's Health Council, 2002). It is significant for this study to discuss how women's identity intersects with homelessness. In order to do so, I will explore issues related to racial and ethnic identity, as well as disability. Though there are many other identities which intersect with homelessness, extensively exploring all of these identities is beyond the scope of this literature review.

As in most industrialized countries, racial and ethnic minorities are overrepresented within the Canadian homeless population (Caragata, 2006). Aboriginal women, for instance, confront incredible barriers to accessing affordable and adequate housing. Aboriginal women's poverty is often acute and much of the housing supply available to them is inadequate and unhealthy (as cited in Callaghan et al., 2002). Research on the City of Toronto has suggested that women of racial minorities and

immigrant women confront similar barriers of race and ethnicity, utilizing shelters at a disproportionate rate (as cited in Brown & Novac, 1996).

Research also shows that racial and ethnic discrimination is a barrier to accessing the housing market, which is a significant means for escaping homelessness. Punam Khosla (2003) explains that racism permeates many organizations and businesses, including those related to the housing market. For example, the Centre for Equality Rights in Accommodation worked with the North York Housing Help Centre to test racial discrimination in the Toronto-area housing market. They found that when the Housing Help Centre referred non-white people to view vacant apartments, they were often told on arrival that the apartment was rented. However, when a white person was sent to view the same apartment afterwards, he or she was told the apartment was available (Khosla, 2003). These forms of discrimination can thwart racialized women's attempts to achieve independence through attaining housing, creating additional barriers for racial and ethnic minority women.

Similar to general statistics on the occurrence of women's homelessness, statistics regarding women of colour may also not fully represent the prevalence of homelessness for this group. Studies show that racial minority women often constitute a significant portion of the marginally housed population (Brown & Novac, 1996). However, studies often utilize a narrow definition of homelessness, which excludes those who are marginally housed and at great risk of becoming homeless. By excluding this group, researchers are unable to fully explore the multiple barriers of racism, language and refugee and immigration status that affect racial minorities (Brown & Novac, 1996). Thus, researchers must seek to employ a broader definition of homelessness that

incorporates the diversity of experiences women have with homelessness, and in particular, exploring issues related to race and ethnicity.

Women with disabilities also face considerable concerns related to homelessness. They often face discrimination and difficulties accessing social support benefits like the Ontario Disability Support Program (ODSP) (Ontario Prevention Clearing House, Ontario Women's Health Network, Toronto Christian Resource Centre & Toronto Public Health, 2006). A recent study by Street Health (2006) that interviewed 85 men and women in Toronto who were homeless found that all were eligible for ODSP. Yet, none received it. The study found that such barriers as difficulty accessing the ODSP application, lack of personal identification and lack of a regular doctor significantly inhibited people who were homeless from accessing ODSP benefits. Women with disabilities who are homeless face considerable barriers to accessing services and benefits, even when they qualify for such supports. Without these supports, women noted that it is incredibly difficult to leave the welfare system and pay for living expenses (Ontario Prevention Clearing House et al., 2006).

The Social Determinants of Health

Health can be studied from many perspectives. One such perspective, the "social determinants of health" (SDOH), is the framework for the current study. SDOH has become increasingly popular among social work researchers. It focuses on the health of individuals, communities, and jurisdictions as a whole by assessing the distribution and availability of economic and social resources. SDOH grew out of research that found that most health problems are caused by the social conditions in which people live and work (Irwin et al., 2006). Researchers now seek to understand health from this perspective by

identifying how members of different socio-economic groups experience varying degrees of health and illness (Raphael, 2006). SDOH adds new insights to traditional perspectives, which focus on biomedical and behavioural risk factors as the causes of good or ill health.

Researchers have developed various approaches to studying the social determinants of health, all of which are concerned with how economic and social resources are organized and distributed in society (Raphael, 2006). Recent Canadian research identifies 11 key social determinants of health for people living in Canada: (1) Aboriginal status; (2) early life; (3) education; (4) employment and working conditions; (5) food security; (6) health care services; (7) housing; (8) income and its distribution; (9) the social safety net; (10) social exclusion; and (11) unemployment and employment security (Raphael, 2004). In addition, social support is also commonly considered as an important social determinant of health (Israel, Farquhar, Schulz, James, & Parker, 2002; Stansfield, 2006). Each of these social and economic resources influences the health of individuals and communities.

Given its focus on social and economic issues, the SDOH framework provides a useful paradigm for studying issues related to homelessness. Traditional epidemiological studies tend to focus on the health effects of poor housing and homelessness in isolation (Bryant, 2004). For instance, such a focus may find the development of illness to be related to poor housing conditions such as the existence of mould or over-crowding in a home. In contrast, the SDOH reframes these features as conditioned by such social issues as poverty and homelessness and impacted by public and social policy (Bryant, 2004;

Irwin et al., 2006). Essentially, the SDOH framework focuses on the social and political environment in which health concerns develop.

Although SDOH calls for a broader perspective to understanding health, many studies on homelessness and health continue to focus on the material conditions of poor housing or lack of housing altogether (Bryant, 2004). Such a narrow focus ignores how the broader social environment impacts health and how social determinants interplay in the lives of individuals and communities (Bryant, 2004). Moreover, few studies about housing and health consider the lived experience of women, especially women with low incomes (Bryant, 2006). This gap in knowledge poses a major challenge to researchers to better understand the social determinants that interact with the health of specific groups of women, such as women who are homeless (Wuest, Merritt-Gray, Berman, & Ford-Gilboe, 2002). Understanding these social determinants of health will also mean that we can better address social and political policies impacting health in order to improve the lives of women and create healthier communities (Wuest et al., 2002).

Women, Health and Homelessness

Extensive research stresses the strong connection between homelessness and health. In order to gain a better understanding of this relationship within the Canadian context, this section outlines Canadian research examining homelessness and its effects on physical, emotional and mental health, as well as on access to health care. Since much of this research includes the experience of both men and women, general health concerns are first discussed, followed by an exploration of women's particular health needs.

Physical Health

The experience of homelessness has a significant effect on physical health. People who are homeless tend to experience a wide range of physical health problems, several of which are chronic; hypertension, diabetes, respiratory problems, seizure disorders, peripheral vascular disease and liver and renal disease are common in the homeless population (Ambrosio, Baker, Crowe, & Hardill, 1992; Daiski, 2006; O'Connell, 2004). One of the foremost Canadian studies on health and homelessness is *The Street Health Report: A Study of Health Status and Barriers to Health Care of Homeless Women and Men in the City of Toronto* (Ambrosio et al., 1992). It included interviews of a representative sample of 458 homeless men and women in Toronto and outlined a multitude of health care concerns this population faced. The study found high rates of many chronic illnesses within the homeless population and also found that the experience of homelessness exacerbated other symptoms of ill health. For instance, many respondents cited lack of energy as a common problem: almost half of respondents (43%) stated that they did not have enough energy to do light physical work. Furthermore, respondents reported higher rates of fatigue and gastrointestinal symptoms than the general population. According to the report, lack of energy, fatigue, and gastrointestinal symptoms can all be stress-related. The experience of homelessness, of not having a place to rest and relax in safety, can significantly influence an individual's health as it can raise stress levels and contribute to various physical health problems.

Living on the street and lacking shelter from the hardships of the outdoor environment further complicates health. Environmentally-related illnesses such as skin diseases, hypothermia, and frostbite are regarded as "hazards of life on the streets" and

can be very severe and lead to early death (O'Connell, 2004, p. 1251). Constant exposure to the street has also been linked to physical trauma. In *The Street Health Report* (Ambrosio et al., 1992) 11% of respondents reported being hit by motor vehicles (such as cars, trucks, or public transit vehicles) in the year prior to the survey, compared with 2% of the general public. The greater incidence of being hit by a vehicle or experiencing environmentally-related illness can be linked to over-exposure in public. Thus, people who are homeless and living in public spaces are at increased risk of experiencing such physical health problems.

Although people living in public spaces may be vulnerable to various health concerns, people utilizing emergency shelters may also experience many health concerns. Because shelters house large numbers of people, those within them are vulnerable to communicable diseases such as tuberculosis and influenza (Daiski, 2006; O'Connell, 2004). Furthermore, maintaining proper medication regimens within the shelter system can be quite challenging; for instance, safely storing medications is often difficult in shelters and many shelters forbid the possession of syringes (O'Connell, 2004).

While people who are homeless tend to experience more physical health problems than those who are housed, prescribed treatment plans for illnesses often do not reflect the realities of homelessness. Even such seemingly simple recommendations as getting enough sleep, eating healthily and exercising present challenges to those without a bed, those who rely on soup kitchens or shelters and thus lack control over their diet, and those who lack the energy necessary to exercise (O'Connell, 2004). Therefore, homelessness not only increases the likelihood of developing physical health problems; it also reduces the ability to improve individual physical health.

The Street Health Report (Ambrosio et al., 1992) examined the incidence of violence experienced by women in Toronto who are homeless. Childhood abuse and physical and sexual abuse were common experiences among those interviewed. The prevalence of childhood abuse was particularly significant. Participants were not asked about this subject directly; yet 9% of women surveyed voluntarily reported that they were physically or sexually abused during childhood (p. 51). Given that researchers did not ask directly about childhood abuse, it is likely that this figure under-represents the extent of this population's experience of childhood abuse.

Women respondents commonly reported experiencing physical abuse in the recent past. Almost half of all women indicated that they had been physically assaulted during the year leading up to the study (Ambrosio et al., 1992, p. 51). It should not be ignored that men, too, reported high rates of physical assault during the 12 months preceding the study (39%); however, 8% more women than men reported this experience (p. 51).

Many female respondents also reported experiences of sexual violence and at higher rates than men. In fact, during the year before the study, 43% of women had received unwanted sexual advances or had been grabbed or touched. Almost half of the women who had experienced sexual violence had been harassed or assaulted five times or more; 21% reported being raped during the year leading up to the study (Ambrosio et al., 1992, p. 51). By comparison, experiences of sexual violence were much less prevalent for men; 14% of men reported experiencing sexual violence during the same period (p. 51).

Issues related to violence and abuse constitute key health concerns that must be addressed by researchers studying the health needs and concerns of women who are

homeless. Women who are homeless are much more likely than women in the general population to experience violence. It has been estimated that 80% of homeless mothers have experienced physical violence and that violence was a major contributor to their becoming homeless (as cited in Deming, McGoff-Yost, & Strozier, 2002, p. 457). Furthermore, 97% of women who are homeless and abuse substances have been victims of domestic violence (as cited in Deming et al., p. 457).

Not only are women who are homeless likely to experience violence, but they also tend to have astonishingly high mortality rates. By examining the mortality rates of women who used homeless shelters in Toronto, Cheung and Hwang (2004) found that women who are homeless and between age 18 and 44 were 10 times more likely to die than women in the general population (p. 1243). Furthermore, they found that this high mortality rate was more prevalent for women under age 45 (p. 1243).

Emotional/Mental Health

Homelessness can also significantly affect emotional and mental health. Daiski (2006) interviewed 24 individuals who were homeless about their health concerns and needs. It was found that participants often lived in constant fear of violence and viewed shelters as particularly unsafe because they often lack security and experience many fights and thefts. Participants described such fear as extremely stressful and had to constantly "look over one's shoulder" due to fear of violence (p. 278).

Many people who are homeless suffer emotionally. Every participant in the Daiski (2006) study described experiencing emotional distress. Participants worried about the effects of homelessness on their mental health; they described feeling excluded from the rest of society and having low self-esteem. These psychological effects of

homelessness have been described as one of the most difficult aspects of the experience; many individuals who are homeless report feeling depressed, lacking control over their lives and lacking respect from other people (Ambrosio et al., 1992).

Mental illness has been associated with homelessness. *Taking Responsibility for Homelessness: An Action Plan for Toronto* (City of Toronto, 1999) indicates that about one-third of the homeless population has a mental illness (p. 114). However, the causes of homelessness cannot be reduced to mental illness (Frankish, Hwang, & Quantz, 2005). Nevertheless, the experience of homelessness itself is likely to exacerbate the duration and gravity of a mental illness, in turn increasing the likelihood of longer periods of homelessness (City of Toronto, 1999).

Deinstitutionalization in the 1960's may be responsible for high rates of homelessness among people with mental illness. The ensuing period has witnessed a dramatic change in how services are provided. The goal of deinstitutionalization was to replace inpatient care with appropriate community alternatives. However, many people became homeless in the process (City of Toronto, 1999). For people in acute crisis, community-based mental health services may not be readily available. In the Greater Toronto Area, there were 80% fewer psychiatric beds in 1999 than in 1960 (City of Toronto, p. 114).

Women who are homeless often report significant concerns related to their mental health. A recent Toronto-based study found that 95% of women experiencing homelessness faced emotional and mental health implications caused by their current housing situation (Kappel Ramji Consulting Group, 2002, p. 68). Women reported that they felt severe stress and anxiety, which influenced their physical, emotional, mental and

spiritual health (Kappel Ramji Consulting Group, 2002). Among women interviewed for *The Street Health Report* (Ambrosio et al., 1992), 66% had attempted suicide during their lifetimes. Furthermore, 10% more women than men had considered suicide during the year leading up to the study (Ambrosio et al. p. 52). Although the causes for attempting suicide are not entirely clear, it remains significant that such a serious issue is more prevalent among women who are homeless than their male counterparts. Research is required to explain these discrepancies and to prompt action to change this reality.

Access to Health Care

Despite Canada's universal health care system, people who are homeless often face considerable difficulties accessing health services. Being homeless can make it difficult to properly store identification, and items like an Ontario health card are often lost or stolen (Ambrosio et al., 1992). Lack of financial resources for transportation to health care providers and for such items as prescription medication and common supplies like bandages also limit the ability of people who are homeless to receive health care (Ambrosio et al., 1992; Daiski, 2006). Dental care is particularly difficult to maintain due to its cost. Unlike other forms of health care, it is not covered under the Ontario Health Insurance Plan (OHIP), and only limited coverage is available under dental programs provided through social assistance (Ambrosio et al., 1992). According to *The Street Health Report* (Ambrosio et al., 1992), people who are homeless are twice as likely not to have received dental care compared to the general population. One-quarter of the study's participants had not seen a dentist in the last five years before the study was conducted (p. 46). Clearly, the experience of homelessness and limited financial resources pose significant challenges to accessing health care.

People who are homeless also face barriers to health care due to inappropriate treatment by health care workers. Negative attitudes and disrespectful treatment by health care workers are cited as leading barriers to health care (Ambrosio et al., 1992; Daiski, 2006; Kappel Ramji Consulting Group, 2002). Ambrosio et al. (1992) found that many people who are homeless report that health care workers do not take them seriously – that they do not listen to them and do not properly investigate their concerns – and that they feel negatively judged by health care staff. Many people who are homeless also lack a regular health care provider and use emergency services, making it difficult to build comfortable relationships with health care staff (Ambrosio et al., 1992). Such negative experiences discourage people from returning to health care settings or speaking honestly with health care workers about their issues.

For many women experiencing violence, access to a women's shelter provides a viable option for escaping abuse. However, women may not access these services until they have experienced prolonged abuse. In the Waterloo Region, a worker at a women's shelter reported that typically "women have been abused 32 times before they come here [come to the women's shelter]" (Dietrich et al., 1999, p. 25).

Women's Unique Health Issues

Recognition of the need for research to focus on women, poverty and health is growing, as studies on women and homelessness tend to stress the importance of the interrelatedness of these issues. *The Street Health Report* (Ambrosio et al., 1992) found that women who are homeless face particular health and treatment issues due to their distinctive reproductive and gynaecological concerns and because they have a greater likelihood of facing physical and sexual violence. For instance, women were found to

have difficulty accessing menstrual supplies due to financial concerns, and many women also had nowhere to store such supplies. The study also explored health care during pregnancy. For women who were pregnant during the study, 81% received prenatal care. However, financial constraints posed a significant concern for five of the 14 pregnant women interviewed, causing them to miss four or more meals during the last month before the study (p. 53). This finding is cause for concern, because women may be able to access formal health care services, but may not be able to obtain material resources needed for their survival.

While the literature on women, homelessness, and health acknowledges women's unique biological (e.g. gynaecological issues), research has also sought to explore other distinctive experiences around women's homelessness and health needs. However, the health needs of women who are homeless may not be well understood by researchers or health care providers. Whitzman (2006) argues that "spatial and policy invisibility" (p. 395) plays a large role in the health of women who are homeless. Whitzman states that the belief that homelessness is mainly a male, urban phenomenon has contributed to the invisibility of women who are homeless in research, resulting in health care services and models that do not address the health needs of women who are homeless. Research must seek out the experiences and voices of women who are homeless, in order to better understand and address their health needs.

Homelessness in Kitchener-Waterloo

Interest in the issue of homelessness in Kitchener-Waterloo is growing; yet, literature on this topic is quite limited. In 1999, the Social Planning Council of Kitchener-Waterloo, the Social Planning Council of Cambridge and North Dumfries, and the

Waterloo Region, Wellington-Dufferin District Health Council released *Understanding Homelessness in Waterloo Region: A Backgrounder*, the most comprehensive report on this issue (Dietrich et al., 1999). The report compiled comprehensive statistical information as well as personal responses regarding experiences with homelessness. Researchers invited emergency and transitional shelter users from 15 participating shelters in the Region to complete a demographic survey about their experiences with homelessness and shelter use. Interviews and focus groups were held with 75 people who had experienced or were at risk of homelessness. Staff from agencies that assist people with housing issues were also interviewed and agency records were examined.

The report's findings explored a wide range of issues related to homelessness. People interviewed who were homeless or at risk of homelessness identified numerous barriers related to obtaining and maintaining housing, such as difficulty finding well-paid employment, insufficient social assistance benefits, as well as abuse, stigma, and discrimination (Dietrich et al., 1999). They also noted that good quality, accessible and affordable housing was difficult to find in the Waterloo Region. Agency staff echoed those concerns and also highlighted that limited program funding poses difficulties for organizations trying to meet the needs of those they serve.

The report also explored issues related to homelessness and health. Most people who were homeless or at risk of homelessness reported that their mental and physical health was "fine" (55% and 58%, respectively) (Dietrich et al., 1999, p. 49–50). However, the remaining individuals noted experiences with a range of physical and mental health concerns, including, depression/bi-polar disorder, stress/anxiety, post-traumatic stress disorder and paranoia/paranoid schizophrenia, substance abuse issues,

back problems, blood conditions, breathing problems, physical injuries, and heart problems. Furthermore, the researchers found that substance abuse and mental and physical health, were key factors leading to homelessness.

Although the report provides the most comprehensive information regarding people who are homeless or at risk of homelessness in the Waterloo Region, it still does not provide an in-depth understanding of this population. Specifically, the report lacks statistics and information regarding women who are homeless or at risk of homelessness. The study did attain balanced representation of genders in the focus groups and individual interviews; however, more men than women answered the surveys sent to local shelters, with a response rate of 73% and 42%, respectively (Dietrich et al., 1999; Waterloo Region Community Homelessness Group, 2001). The surveys were important because they provided the data used to develop a demographic profile of the homeless population in the Region. However, since fewer women than men answered the survey, the researchers concluded that the "demographics more accurately reflect the realities of life for men than for women" (Dietrich et al., 1999, p. 54).

The report did not fully capture the voices of women, but it did reveal trends in the Waterloo Region that highlight the importance of developing a deeper understanding of the experiences of women who are homeless. For instance, the Region has one-third more shelter beds for women than men, but these are still more frequently filled beyond capacity (Dietrich et al., 1999). Furthermore, more than half all of emergency shelter residents in the Region are women. In fact, women comprise more than 60% of the literally homeless in this area, which researchers believe is "significantly higher" than in other Canadian cities (Dietrich et al., 1999). However, as local research does not explain

why this considerable disparity has occurred, one of the report's recommendations is that more research into the experiences of women who are homeless in the Waterloo Region is required (Dietrich et al., 1999).

Community-based groups have echoed many of the concerns raised in the report. In 2001, the Waterloo Region Community Homelessness Working Group (now the Waterloo Region Housing and Homelessness Umbrella Group) noted in its *Waterloo Region Community Homelessness Plan* that the Region currently faces an increasing issue in terms of access to affordable and appropriate housing (Waterloo Region Community Homelessness Working Group, 2001). The plan also takes issue with the lack of research and information available regarding women who are homeless in the Region. Given the lack of research about women and homelessness in the Waterloo Region, researchers should actively seek out the voices of women who are homeless, in order to develop a more comprehensive profile and understanding of the issues of homelessness in the Waterloo Region.

In *"You can't understand it until you go through it": A Handbook About Homelessness in Kitchener-Waterloo*, Nadia Hausfather (2005) introduced the voices of those who have experienced homelessness. Her objective was to inform homelessness concerns in the community. Hausfather used numerous secondary sources, but centred the handbook around interviews with seven individuals who have experienced homelessness and two middle-class homeowners. The handbook presents general information regarding homelessness, including definitions, common experiences and causes of homelessness, as well as possible solutions, with a strong focus on the Kitchener-Waterloo experience. As part of a wider initiative to educate the broader

community on homelessness concerns, this handbook serves to provide a range of information within a local context.

The handbook provides a wealth of knowledge gained primarily from those with lived experience, but diversity within the experience of homelessness is not explored. Hausfather's findings are mainly generalized to the entire homeless population, leaving questions about women's particular experiences. By focusing on the voices of women who have experienced homelessness, researchers can effectively align their studies with the direction of Hausfather's research and deepen our understanding of the complexities of homelessness.

Summary of the Literature Review

Previous literature notes that women are increasingly experiencing poverty and homelessness (City of Toronto, 1999; Townson, 2000). However, due to a lack of visibility in the public sphere, it is often difficult for researchers to locate and study women who are homeless, which would further understanding their experiences (Kappel Ramji Consulting Group, 2002; Lenon, 2000; Ontario Women's Health Council, 2002; Radhika, 2004). Research must also address concerns related to diversity in order to gain more nuanced understanding of the relationship between women, homelessness and health (Brown & Novac, 1996). Ultimately, research on homelessness needs to focus on the experiences of women, while honouring wide and varied experiences within this population.

While there is extensive literature concerning the health of women who are homeless, much of this research actually integrates both women and men's experiences (see Ambrosio et al., 1992; Dietrich et al., 1999; Hausfather, 2005). While combining the

experiences of women and men provides much insight on the health of people who are homeless, combining experiences leaves questions regarding women's specific situations. Such a focus on women is of particular importance, given that social determinants such as gender strongly influence health (Bierman & Dunn, 2006; Bryant, 2004; Irwin et al., 2006; Raphael, 2004; 2006; Spitzer, 2005; Wuest et al., 2002). It remains that gender, homelessness, and health are inextricably linked (Raphael, 2004; Wuest et al., 2002). Therefore, the gendered experience of homelessness must be explored in order to gain a more thorough understanding of health and homelessness. By focusing on the health of women who are homeless, researchers can effectively address this research gap.

Focusing on the experiences of women who are homeless is particularly appropriate for a study of the Waterloo Region. Previous local research, as well as community-based groups, have indicated a need for studies on women who are homeless. Statistics indicating higher rates of homelessness among women in the Region and women's under-representation within local research on homelessness suggest this need (Dietrich et al., 1999; Waterloo Region Community Homelessness Working Group, 2001). Delving into this issue will facilitate insights into the Waterloo Region's concerns, strengths and needs.

CHAPTER THREE

METHODOLOGY

This chapter will explain the purpose of the current study and its methodology. Methods used to gather and analyze data, participant demographics, ethical considerations and limitations and strengths of the study will be discussed.

Purpose

The purpose of the current research is to examine the relationship between women who are homeless and their health through the experiences and voices of women who are homeless or have experienced homelessness in Kitchener. The objective is to explore how women experience health care access as well as social determinants of health such as housing, income, food, employment, and social supports. The study will also examine the implications of these findings within the context of the Region.

The following research questions guide the study:

1. What factors influence access to health care and other social determinants of health (such as housing, employment, healthy food, income and social support) for women who are homeless?
2. What is the impact of homelessness on the health of women?
3. What do women who have experienced homelessness in Kitchener assert to be appropriate recommendations for change in relation to their health needs?

Theoretical Frameworks

Several theoretical and methodological frameworks guided the research. This section explores each framework and its usefulness to the study. The frameworks are: (a) social constructionism; (b) socialist feminism; and (c) participatory action research.

Social Constructionism

Social constructionism is an umbrella term for various theories that focus on the

importance of socio-culturally and situationally constructed aspects of human life and experience. Social constructionists are also critical of traditional social science and its use of positivist assumptions as the foundation of its methodology (Robbins & Canda, 2005). Positivist research emphasizes objectivity and generalizability (Rubin & Babbie, 2005). To positivists, an objective external reality exists, even when recognizing its elusive nature (Rubin & Babbie, 2005). Though contemporary positivists tend to recognize the inability to be purely objective, they nevertheless still attempt to anticipate and minimize the impact of non-objective influences (Rubin & Babbie, 2005).

Social constructionists question such assumptions regarding reality. They view reality, people's identities, and communities as constructions of the mind (Robbins & Canda, 2005). For social constructionists, social reality is not fully knowable; instead, they argue for a relativism in which each individual's own subjective view of social reality is as valid as another's view (Rubin & Babbie, 2005). Critics of this view may question how social constructionists can declare anything to exist, if there is no external reality. However, researchers can gain an understanding of people's social reality, and one of the means by which to achieve this, is through exploring people's subjective interpretations of reality (Rubin & Babbie, 2005).

Social constructionism served as an appropriate framework for the current research, as it seeks to gain an understanding of the experiences of women who are homeless in relation to their health. This framework was especially useful in designing and analyzing the research, as it helped to maintain a focus on the realities of each participant and ensured that the research respected each participant's experiences, accepting each one as credible and reliable. Rather than attempting to produce a

generalized theory regarding women's health and homelessness, this study seeks to gain a better understanding of how a particular group of women experienced this relationship. That being so, my study understands women's subjective view of social reality as a valid and useful contribution to understanding the relationship between homelessness and women's health.

Socialist Feminism

Feminism is a broad term that encompasses many feminist theories. All feminisms share an analysis of patriarchy, which privileges men over women, and a desire to end the oppression of women (Annandale, 1998). While I have been influenced by many feminist theories, I find socialist feminism to be particularly suited to providing a framework for the current study.

Socialist feminism may have been at its peak in the 1970s, but it is still relevant and useful today (Holmstrom, 2003). It developed during the women's liberation movement, as a theory which combines Marxism and radical feminism (Holmstrom, 2002). It incorporates a range of foci; Barbara Ehrenreich says it is "really socialist internationalist antiracist, anti-heterosexist feminism" (Ehrenreich, 1976, as cited in Ehrenreich, 2005). Although the meaning of socialist feminism is sometimes contested, taken in a broad sense it extends a class and gender analysis to include other identities such as race, ethnicity, and sexual orientation (Holmstrom, 2003). Significantly, this approach focuses on class as central to women's oppression, yet distinguishes itself from Marxism by not reducing the oppression faced by women to primarily economic factors (Holmstrom, 2003).

Socialist feminism addresses gender injustice by analyzing capitalist forces, since these forces have a significant role in women's oppression (Holmstrom, 2002). Given socialist feminism's focus on class and capitalism, it is especially pertinent today. Growing distrust of and protest against capitalist forces can be seen in demonstrations like those against the World Trade Organization (WTO) in Seattle and Quebec City (Holmstrom, 2002). The negative economic consequences of capitalism are particularly felt by women. Women around the world are more likely to be poor, and to work in insecure employment. As a result, they are disproportionately affected when social services face significant cuts and welfare is reformed (Holmstrom, 2002). A socialist feminist approach is useful for my study, as women who are homeless in Ontario have faced the burden of significant cuts to social service programs and policies, such as the drastic reductions made in the mid-1990s to social assistance rates (Novac, Serge, Eberle, & Brown, 2002). Consequently, the role of policy will be addressed in my study, as the ability of women to attain the resources needed in order to live has been substantially reduced.

Socialist feminism also serves as a useful theoretical framework for the current study, given its focus on intersecting identities such as race and ethnicity, which is particularly useful when approaching the diversity of women's experiences. As a researcher, I maintained a strong focus on diversity and made significant attempts to involve women from diverse backgrounds in order to inform the study's findings. By doing so, I hoped to gain a more thorough understanding of how women experience homelessness and seeing the influence this experience has had on their lives and, particularly, on their health. Socialist feminism has been criticized for not centring its

analysis on race (Bhavnani & Coulson, 2005). Thus, it is important to recognize the racism of many feminist traditions and to focus on race, along with other identities, as fundamental to this approach.

Participatory Action Research

Participatory action research (PAR) serves as another theoretical and methodological guide for the current study. Key to this methodology is a focus on a collective process of investigation and education, as well as the action components of research, which include both the researcher and research participants (Kidd & Kral, 2005; Maguire, 1987). This approach supports the notion that research participants should be able to have a meaningful decision-making role within research in order to increase their own empowerment and transform society by developing collective action (Kidd & Kral; Maguire). Therefore, PAR provides a framework for an emancipatory research process with the goal of facilitating social change.

The current study did not fully utilize the PAR approach, but it did incorporate aspects of it. This framework was beneficial to the study, because it yielded findings that better reflect the opinions and viewpoints of the participants by increasing their role within the analysis of the research. Furthermore, the approach gave voice to the women involved, who are often silenced and ignored within research. This study made use of PAR by respecting that women who have experienced homelessness are experts in their own lives, and sought to ensure that their involvement in this study was meaningful. For instance, all participants were paid for their time as a tangible acknowledgement of the worth of their knowledge and contribution to the study. Participants received $50 for individual interviews and $30 for focus groups. During the focus group, participants

discussed the initial analysis of all of the interviews and decided whether the information reflected their experiences and opinions. This process served two purposes: to increase the trustworthiness of the information obtained and to increase the role of participants by being actively involving them in data analysis (Harrison & Morton, 2001).

PAR was also used to explore which recommendations for change participants felt would best suit their lives and improve their health. This involvement gave participants an opportunity to not only voice their opinions, but also to develop direction in advocating social action and justice. By exploring participants' viewpoints and opinions, the study's findings may inform policymakers and the general public of possible areas for change. The focus group provided an opportunity for participants to share their opinions and experiences with others, thereby presenting the opportunity to develop friendships or partnerships for creating change. Focus group members also discussed what should be done with the information from the study, and I am committed to realize their recommendations. While the current research does not follow every tenet of PAR, it is heavily influenced by this framework in providing an empowering role for participants and focusing on respecting participants' knowledge, contributions, and recommendations for change.

Methods

Research Design

The study took on an exploratory approach to examining the relationship between homelessness and women's health in Kitchener. A qualitative approach was followed, which involved 10 individual semi-structured interviews and one focus group with women who are homeless or have experienced homelessness in Kitchener. Data was

analyzed using grounded theory, which focuses on the development of themes in order to create theories that are grounded in the data collected. This approach was fitting, since it allowed the research and theories to be guided by the lives, experiences, and insights of participants (Creswell, 1998; Rubin & Babbie, 2005; Schram, 2003).

Research Participants

Participants were recruited through advertisements in all services and organizations in Kitchener and Waterloo that serve women who are homeless. Organizations received a poster advertisement of the study and some organizations requested an abstract of the study, which was provided to them (Appendix A-B). This yielded a non-probability purposive sample, as only those who self-identify as women who are homeless or have experienced homelessness in Kitchener were selected (Babbie & Rubie, 2005). From July to September 2006, over 30 women contacted me by phone or e-mail, expressing their interest in participating in the study. Given my commitment to diversity, reasonable attempts were made to select participants with a range of life experiences and identities in terms of race, age and ability. Of the 10 participants in the study, one was of Indian descent, one was Black, and one was an Aboriginal woman. Seven participants were Caucasian. One woman was in a wheelchair, and the other participants were able-bodied. One woman was not a Canadian citizen and one identified as Jewish. Participants ranged in age from 19 to 59.

Participants had varied experiences with homelessness. All had experienced homelessness in Kitchener, having slept on the street, in shelters, in the Out of the Cold program, in friend's homes and in one case, in a church building. Three participants were homeless during the time of the study. Duration of homelessness ranged from one month

to 15 years. Three participants had been homeless numerous times and in different cities or towns.

In order to gain a sense of the women who became involved in this study as research participants, I will provide brief life stories of them. The stories are drawn from research questions I asked during the interview process. However, I did not embark on this study with an intention to produce life stories, and as a result there are gaps and omissions; the stories also vary in length. Nonetheless, they provide some insight into the lives and experiences of the women involved. The names of the research participants have been changed to randomly selected pseudomons for confidentiality purposes.

Anne

Anne was 42 years old. She was originally from Kitchener and had one teenage daughter. She described having a "bad upbringing," as her parents had "week-end vices," leaving her on her own much of the time. She moved out when she was 15 years old and at 16, was working at a full-time job. She eventually trained as a hairdresser.

Anne became homeless in her 40s after moving to a rural area outside of Kitchener with her partner. She described how this move to the country was supposed to improve their situation, but led to increasing isolation and poverty, on top of which her partner became controlling and abusive:

> *. . . everything was going to be better up in the country, but it wasn't. There was no resources. Very low employment. Being out in the country, you need a vehicle. He had the vehicle. Old fashioned lifestyle, which, "I'll look after you, you stay home cook the meals, and I'll pay the bills and what not." But then it became mentally abusive, hard on me. So that ended up working on my nerves, working on my self-esteem. And it then became physical abuse.*

Anne's partner was not only physically and emotionally abusive, but also stopped providing for the family, even though he was the only one with an income during this

time. She explained that her partner "didn't provide food, and he wasn't providing the bills. I had no phone." Anne lived in this abusive situation for five years, and described how her self-esteem and self-worth deteriorated considerably. As a result of the abuse, Anne's teenage daughter moved out and became homeless:

> *. . . she [Anne's daughter] ended up going out on her own and she became homeless also, because she couldn't handle the environment, seeing her mother in this position, seeing the two of us unhappy. And then that would be the guidance. I mean that's all she's seen, these last five years. And that's her teenage years. She's thinking, screw this, I'm out of here. So she would sleep at her friends, made bad choices as well.*

Anne explained that she could not rely on her family or friends for help during this time. She explained that her family "didn't want any part of me," they "just didn't understand, they're old fashioned, they think you should just try to work it out." She also feared asking her friends in Kitchener for help; she felt "unworthy" and that she was to blame for her situation. Instead, she moved into a shelter and lived there for four months.

At the time of our interview, Anne and her daughter had reconnected and moved in together. She explained that they were working on healing: "we're still trying to get the pieces put back together. It takes a lot of counselling."

Emily

Emily was 22 years old. At the time of the interview, she had a two-and-a-half-year-old daughter, was eight months pregnant and was living in housing made available by an organization providing housing and support services for young mothers. She was from a town north of Kitchener, but had lived in Kitchener since she was a child. She described having a "rough childhood" and that her "parents divorced when I was a kid." She explained that her "mother married three times" and that she was "in and out of all of those relationships."

Emily was homeless for three months in the winter of 2005 after getting into a fight with her mother and having "nowhere to go." She lived on the street and in churches; she "couch surfed" in the homes of her friends, and lived in a local shelter. Eventually, a friend's mother allowed Emily to live in her home, helping her to escape homelessness. She also described being politically active, as she took part in the "squatters' meet" and "broke into an abandoned home and protested that the city should hand it over to the homeless."

Family and Children's Services took Emily's daughter when she was five or six months old, giving her to Emily's mother. At that time, Emily said she was "glad she is with my mom" because she "wouldn't know what to do with a child on the street." Now, Emily was visiting her daughter once a week; she explained that she was "able to keep her second child."

Sarah

Sarah was 49 years old and the oldest of four children. Her parents met at a boarding school, but had very different upbringings: her mother was from Toronto and her father grew up on a farm. She said that her mother, who was young, "didn't want to be a mother as young as she was," so it was Sarah who "ended up being the mother" to her siblings. Sarah left home at 16 years of age, which she explained was teenage "rebellion." She married at 17 and left her husband two years later, "because he was abusive." However, she explained that her first husband was "not as bad as the guy I ended up with."

At 20 years of age, Sarah remarried and eventually had four children with her husband, who was also abusive. She described her husband as "a very troubled guy."

Though he completed "all kinds of programs," such as an addiction program, "none of it worked, really." She explained that she had escaped this abusive relationship, almost unintentionally. She felt that her husband was going to attack one of her young sons, so she called 911 but did not speak to anyone. Instead, she hung up the phone when her husband "didn't come at us," not realizing that "they [911] call you back and they have to send somebody." She explained that this "was the best thing that happened," as she was able to get herself and her children away from this abusive situation.

Sarah was homeless for three and a half months with her youngest son. Her other children were older and mostly living on their own, although her one daughter, a high school student, was boarding with "a young couple" during this time. Sarah and her son had arranged to stay in a "building that our church at the time had, or that they held, well, church-wide events, or Sunday school classes or whatever" for about a month and a half. They still had not found housing at the end of this period, so they moved into a shelter for two months.

Now, Sarah and her son were living in community housing. She explained that "luckily, we weren't homeless for like a huge, extended length of time like we could have. I was dreading going into the winter being homeless." She was also quite focused on teaching her son about recognizing and dealing with his feelings. She explained that her children did not recognize their feelings, as it was "dangerous to get angry in their household." So now, she teaches her son who lives with her: "whatever you feel is cool" and "it's not for someone else to judge you for how you feel."

Asha

Asha was 59 years old. At the time of our interview, she was living in a shelter. She had lived in the shelter since 1991 and explained to me that the shelter workers were encouraging her to leave and find permanent housing. She was very distressed about this situation, as she could not find housing that she felt was appropriate. Also, no explanation had been given to her as to why she had been allowed to stay in the shelter for over 10 years and now was being told to leave.

She had a master's degree in psychology and had completed many courses at a local Kitchener-Waterloo university. She immigrated to Canada from India in the 1970s with her husband. She explained that when she came to Canada, she became "a housewife and student." She was also in a music group. She sang South Asian music and her husband was learning piano. However, Asha's life changed very drastically in the 1980s, when she and her husband divorced. Not long after this, Asha moved into the shelter (she never fully explained why during the interview). She described feeling very isolated as she "has had one or two visitors the whole time and no telephone calls."

Asha had one income source – investments from her former husband, who had since passed away, which limited her ability to pay for housing. However, after our interview, Asha did find housing and was now living in an apartment.

Liz

Liz was 19 years old. She had one older sister and two younger brothers. The first time she was homeless, Liz was only 12 years old. She explained that she was homeless off and on between the ages of 12 and 14. During this time, she lived on the street and in

other people's homes. She described being "officially kicked out" of her house at 14 years of age.

While living on the street, Liz slept under a bridge during the spring and summer and "couch surfed" and lived in churches through the Out of the Cold program, when the weather became colder. She explained that she spent "six months living on the street," but including other forms of temporary shelter (i.e. "couch surfing"), she was homeless for about a year. She lived with a group of friends and explained that she was not "upset about being homeless, because I never really had anything to lose."

At 14 years of age, Liz was "diagnosed with being bipolar," but stopped taking the medication that had been prescribed to her at age 15. She explained that she does not "see a point to take it" now, since she has been off medication for a few years and that she "doesn't like the idea of being on medication."

At the time of our interview, Liz was renting a room in a boarding house. Though Liz explained that her homeless experience was not very distressing, she explained: "now, I have stuff, so I'd be upset if I became homeless." She also explained that over the course of the last year, she and her mother have become "best friends."

Kathleen

Kathleen was a 22-year-old student. She was originally from Kitchener, but also lived in Toronto for some time. At the time of the interview, she had recently moved back to the Kitchener area in order to attend university. Though many university students rely on their family for financial and emotional support in order to attend and complete school, Kathleen explained: "I've been living on my own since I was like 16 years old." In fact, she spoke very little about her family and explained that her father had passed

away and that she rarely spoke with her mother. She also has not had contact with her siblings in "maybe like four or five years."

In order to financially support herself, Kathleen "was on assistance for most of that time [during adolescence]." However, the financial support provided through social assistance was not enough and she had to work "odd jobs here and there" to support herself. For housing, Kathleen relied on youth shelters. She described these shelters as not "so, so bad" and was quick to describe the positive aspects of one particular youth shelter:

> *They help you to find housing, jobs. And they also, you get to go on free trips, or like other times we went to the zoo, they took us to the Princess of Wales Theatre, sometimes if there's tickets to like the Raptors games, some of us could go. They have little job search groups, that you could go and just like have coffee and stuff.*

Though Kathleen was able to find housing when she moved back to Kitchener for school, she was soon forced back into the shelter system. She "got kicked out" of her accommodations, but did not have the enough money to rent an apartment. Since new rental agreements often require first and last months' rent, a new renter requires a significant amount of savings. But since her need for housing was immediate, Kathleen moved into a local shelter. She explained that at this shelter "you're sort of on your own" and that it had "more of an individual plan" than the group-focused youth shelter. In her experience, she found that shelter workers "provide a list of housing and stuff" and that is "that's the extent to how it goes."

Kathleen stayed at the shelter for "a little over a month." For Kathleen, the shelter experience "wasn't that bad" because it was "better than staying in the street," which would have been her only other alternative. She was able to get out of the shelter through social assistance – she started to receive welfare. Also, she found housing from "one of

the lists" of available local housing that the shelter receives and supplies to residents. At the time of the interview, she was now renting a room in an apartment with three other tenants.

Diana

Diana was 40 years old and an American citizen. She had moved from place to place in the United States for much of her life. She explained: "I like to travel, I like to move." She was "raised in Michigan" but her teenage years were spent "between Michigan and Texas, and going back and forth." She explained that when she would get "into a fight with my dad" she would be "sent to my grandparents" in Texas. Consequently, she had "two homes and two sets of authority figures." She explained that her grandparents provided a "very stable, very structured home" but her own parents largely neglected her growing up.

Diana came to Canada after becoming pregnant. She and her partner, who is Canadian, were having a child. Her partner "wanted me to come up here [to Canada], so our child would be born in Canada and be a Canadian citizen." However, soon after coming to Canada and having the child, Diana found out that her partner "found another girlfriend." Now, though no longer in a relationship with her partner, Diana was living in Canada "because he [Diana's former partner] is fighting me for custody of my daughter."

Although Diana did have an income from disability insurance, it was not enough to pay for the housing she needs. Diana had specific housing needs, since she used a wheelchair. She explained that she "can't get an apartment" because "accessible, financially available housing, without subsidy, it doesn't exist." Therefore, she faced a

significant barrier to attaining housing, since she "can't get subsidy or government assistance, because I'm not a Canadian citizen."

In order to stay in Canada due to pursue her legal battle with her former partner, she had been forced to live in a shelter. She explained that the shelter she was living in during our interview was "one of the few shelters I called that actually was fully accessible." However, due to her need of assistance in caring for her daughter, she did not feel comfortable having her daughter live with her:

> *You know, if I was in a home situation, where I knew I could have access to what I needed, it's different when you're in your own place and it's your own things and you can get around, and you can do what you need to do. I'm not in that situation, so I didn't want custody of her. So, she's with him [her former partner].*

During my last conversation with Diana, she said she had find housing and has since moved out of the shelter. However, she was persisting in her legal battle for her daughter.

Nancy

Nancy was 42 years old and was "born and raised in Buffalo." She had two sons and one daughter, who at the time of the interview were all currently teenagers. Though Nancy did not have regular contact with her children, she spoke very highly of them and hoped to reconnect with them. Her two sons lived with their father. Her "oldest son just went off to the service last year and my middle son is looking at graduating [highschool] this coming year." Her daughter was 13 years old and lived with Nancy's brother-in-law.

As a child, Nancy and her family "moved to an Indian reserve south of Buffalo." She explained that her "dad's Seneca and my mom was Mohawk but she has Canadian status." Since her father did not have native status, when Nancy's mother married him, "something about the laws, she's no longer considered native, because she married non-

native status." Nancy was the youngest of five children, and the pressure to succeed was intense. She explained that "everybody placed their hopes and dreams on me because I was the youngest" and she felt forced by her parents to become a nurse.

Nancy did become a nurse and "worked in health care for like 13 years" in the United States. After suffering an injury on the job, Nancy was no longer able to work and said that she not only lost her job, but "lost um, a lot of things." She started to "struggle with alcoholism." She gave up custody of her children and sought "treatment, rehabilitative treatment for alcoholism and that, and um, that's when they diagnosed me with bipolar." She eventually moved to Canada.

Nancy has struggled with periodic homelessness. She said that it often "starts with the, the alcoholism, because then I just, I fall into the depression and I just don't care." Her last experience with homelessness occurred after living in inadequate and unsafe housing. She explained that the landlord "was letting a lot of criminals move into the building" who "ruined the place" and were regularly doing drugs. As Nancy was trying to remain sober, she needed somewhere else to live. So, she moved into a shelter, where she stayed for three months. From this experience she explained that she "got hooked up with a social worker and a doctor" and has been working on improving her health.

Currently, Nancy was living on her own in an apartment and working full-time in sales. Becoming accustomed to living alone and being housed has been difficult. Nancy explained that she is "trying to get used to being with me, in a home, and that is still so overwhelming." She explained that for her "the biggest struggle" right now is "feeling like I deserve." But she has been trying to get used to being able to rest and enjoy herself:

> *. . . finally after 10 years I decided I was going to make a major purchase and I bought a VCR, the VHS-VCR-and CD combination and it keeps me home and I*

> *watch movies and I'm like wow man, this is, like it makes me feel different. And it's like I've never had this, like I don't have to rush, and I can sit and relax and watch this movie and turn it back if I want and laugh out loud if I want to, you know and it's really, it's really amazing.*

Nancy was working on "trying to make an example" for her daughter to look up to and to become "stable enough to have my kids for a visit on my own." She remained hopeful and believed "there's got to be a happy ending somewhere."

Jacklyn

Jacklyn was 30 years old and had two young sons. She was originally from eastern Ontario and had lived throughout eastern and southern Ontario. Her childhood home was very abusive; she described her mother as "very mentally ill" and her father as a pedophile. She ran away from home and described herself as "always running from something." Reflecting on her life, she explained: "I'm not going to say I've had a horrible life, but it was definitely not easy."

Jacklyn had been homeless many times and suffered from depression, anxiety, and post-traumatic stress. Her last experience with homelessness occurred after leaving her abusive husband. She lived temporarily in the house of her friend and her friend's partner, but they began exploiting her financially and sexually. Luckily, she was able to move into a local shelter, where she was able to get some assistance with her mental health concerns. However, during this experience Family and Children's Services apprehended one of Jacklyn's sons, due to his violent and aggressive behaviour, and he was now "a ward of society."

Currently, Jacklyn was living in a supportive living environment with her younger son. She explained that she was now "just trying to adjust" since this was the first time she had lived on her own. During our interview, she expressed intense guilt for the

emotional issues of her older son, which she feels was caused by her living situations: "I guess the fact that I've moved around a lot because of the situations I've been in. Um, might have an effect on my older son's mental health." She further explained that "he's [her son] encountered his own abuses because of the situations maybe I've been in." Nevertheless, Jacklyn had been actively working to keep her family together and improve the health of her children. She had been working with a local children's health organization, in order to effectively address her son's behavioural and emotional concerns and was planning for her son to return to her home.

Becky

Becky was 28 years old and was the oldest of five children. Though born in a nearby city, she had lived in Kitchener since she was a teenager. During her teenage years, Becky's parent's divorced. She felt strongly affected by the divorce, since she was very close to her parents. At 17 years of age, she moved into her boyfriend's house. Not long afterwards, their relationship dissolved and Becky moved into another friend's home. When high school resumed in September, Becky's guidance counsellor encouraged her to apply for student welfare. With this financial support, Becky was able to rent an apartment with a roommate.

While living in the apartment with her friend, Becky also had a boyfriend. However, her boyfriend started to become controlling and abusive. The abuse escalated when Becky became pregnant and later gave birth to their son. She was able to escape the situation and moved into a hotel. However, she only had enough money to pay for one night, so she entered a local shelter and stayed for a month.

Over the next little while, Becky stayed with her father and then returned to another shelter. After being put on a housing waiting list, she eventually got an apartment in a supportive living environment and had successfully applied for the Ontario Disability Support Program (ODSP). However, Becky's struggles were continuing, as she was suffering from chronic depression and anxiety attacks, and in an extremely distressing development, she lost custody of her son to her mother-in-law.

Data Collection

Qualitative interviews served as the primary means of data collection. This approach to data gathering was particularly useful because it provides in-depth, information-rich data. Qualitative interviews also give women the opportunity to voice their own opinions and experiences, which allows research to incorporate a wide range of viewpoints and better reflect the realities of participants.

I conducted interviews using an interview guide developed for that purpose (Appendix C). I asked all interview participants the same questions about their experiences with homelessness, its impact on health and access to health care. The guide also included specific probes to obtain information that may not have emerged through the standard questions. A semi-structured approach allowed flexibility in the interview process. Questions arose throughout the conversation as topics were brought up, allowing for a more informal and open interview. Participants had the option of being tape recorded; for those who declined, I took notes during the interviews.

Interviews took place in a variety of settings. I asked participants where they would like to have the interview, in order to accommodate their needs and make them feel more comfortable during the interview. Interviews took place in a park, coffee shops,

a shelter, a social service organization, a public library, a school classroom and in a participant's home.

I invited all interview participants to attend the focus group. Of the 10 invited, 6 took part. I also designed another interview guide for the focus group, which followed a semi-structured approach (Appendix D).

After an initial analysis of information collected from the individual interviews, I met with the focus group. As a group, we discussed my findings and I asked participants the questions from the interview guide. These questions focused on how credible they felt my analysis had been and provided space for women to suggest areas of improvement. I wrote participant responses on a flip chart, which enabled a mutual verification process, whereby research participants and I could confirm that comments were documented accurately. I also took notes during the focus group to capture any other responses or dialogue I thought were relevant to the research questions.

Using both individual interviews and a focus group ensured trustworthiness. One way in which researchers can ensure trustworthiness is by establishing data credibility (Harrison & Morton, 2001). I ensured data credibility by using multiple qualitative methods for data collection. The member checking procedure was also used during the focus group to ensure data credibility, since group members verified the accuracy of the themes developed from the individual interviews (Rubin & Babbie, 2005).

Data Analysis and Verification

I analyzed data from the individual interviews and focus group and identified themes in the experiences, opinions and suggestions from participants. The principles of grounded theory method (GTM) guided the data analysis. GTM allows the development

of theories based on patterns within observations (Rubin & Babbie, 2005; Strauss & Corbin, 1990). GTM was a fitting approach for the current study, since its goal was to develop theories based on the experiences of participants.

In order to incorporate the focus group feedback effectively, I separated the analysis process into two general phases – before and after the focus group. Both phases involved open coding, which includes examining and categorizing data. The data included interview transcripts and notes, as well as notes I took during the focus group (Strauss and Corbin, 1990). I coded each research question and response individually, by writing key words on the sides of the pages which research participants articulated themselves or that I believed appropriately described their response. I also explored the relationships between more general codes, their categories, and larger concepts within the texts. For instance, for the research question regarding the impact of homelessness on health, I grouped together experiences which caused stress. The categories and themes I developed were discussed during the focus group. I only included those themes mentioned by two or more participants in the focus group discussion in order to protect participants' confidentiality.

The focus group portion of the study provided feedback on the analysis emerging from the interviews and thus verified its trustworthiness. A common observation during the focus group was that my initial analysis was too focused on health care access and biomedical health concerns and downplayed social aspects like employment, which also influence health. With this input and additional data from the group, I re-read and further analyzed all of the interview transcripts and notes with more attention to social factors. All participants were offered a copy of their interview transcript and an opportunity to

revise or clarify the data.

During the focus group, we also decided on the future directions for the study. Using a flipchart, we brainstormed ideas regarding how the study's findings should be used and decided that a community report would be developed and distributed to local organizations. Also, all research participants will receive a copy of the report, once completed.

Ethical Considerations

Various ethical concerns surfaced in planning and carrying out the study. Primarily, these concerns arose from the interview and focus group phases, as well as from the nature of the study as a whole. Since I asked participants to talk about their experiences with homelessness, which was sometimes emotionally painful, I was sensitive to this concern. Before conducting interviews and the focus group, I told participants that they were free to not answer questions and could terminate their involvement with the study at any point without penalty. When participants showed signs that they were uncomfortable, I reiterated their freedom to ignore questions or leave the group.

During the interview phase of this study, an ethical concern arose regarding the places interviews were held. In order to help participants feel comfortable during the interview process, participants chose the locations of their interviews. However, one of the participants chose to conduct the interview within the shelter she was living in. This location created an ethical concern, as shelter workers may become aware that the woman was participating in the study and workers may be concerned that the shelter would be described in a negative light. However, this location was also important for the

participant's comfort, as she uses a wheelchair and the shelter is fully accessible. In order to balance the participant's choice and comfort as well as possible ethical concerns, I ensured that the interview took place in a private area within the shelter, so that workers could not hear our interview.

The sensitivity of the subject matter also necessitated that confidentiality be assured for all participants. I ensured confidentiality by omitting information that could identify participants from any documentation of the research, including transcripts. During the focus group, I only discussed the themes raised by more than two participants during individual interviews so those participants could not be readily identified in the group. Also, I kept all transcripts in a secure location and will destroy them once the research is completed.

Given the personal nature of the data gathered during the study, it was important that all participants be aware of how information would be collected and that they have documentation verifying these procedures. All participants provided informed consent by signing a consent form before the research was conducted (Appendix E). This form outlined the goals and purpose of the research, possible use of its findings, privacy rights and possible risks.

Limitations

The study's findings are limited by a number of factors. Because I am only fluent in English, the study sample included only women with at least a working knowledge of English, which limited the study's representation of the homeless population in Kitchener.

The study gathered input only from women who experienced homelessness.

Gathering input from health care providers would contribute to a deeper understanding of the relationship between women, health, and homelessness. However, the goal of the current research was to examine the perceptions of women who have experienced homelessness. By focusing solely on women who are homeless, this study yields a more nuanced view of their experiences, opinions, and recommendations.

Sample size and approach also pose limitations. Given the small sample size and use of a qualitative approach, the study may not fully represent women who are homeless or have experienced homelessness in the City of Kitchener. Originally, it had been planned that the study would incorporate women from both Waterloo and Kitchener; however, it proved to be quite difficult to find women with experiences of homelessness in the City of Waterloo. This may be due to the fact that recruitment advertisements were placed only with services and organizations for people who are homeless, most of which are located in Kitchener. Future research on homelessness in Waterloo should focus on individuals who may not typically access formal social services and organizations. Late in the research, a community activist recommended seeking advice or assistance from religious organizations in recruiting research participants who have experienced homelessness in Waterloo.

Strengths

Given that studies of the Waterloo Region have been limited in their exploration of the experiences and needs of women who are homeless, the current study fills a gap in local research. Furthermore, health research and practice have become increasingly focused on the social and political forces that influence health, and the current study contributes to this development in its focus on the social determinants of health. The

study is also a valuable reflection of the voices and experiences of women who are homeless, particularly as related to their health concerns. Ultimately, by exploring the social and political factors that influence the health of women who are homeless, the current study provides direction for future advocacy and activism in order to improve access to the resources that promote health.

Activism and advocacy can occur and be focused at all levels of society – from the international sphere and even in one's own home. For me, the key to advocacy and activism is a goal to create social change. Like Shragge (2003), I think that social change begins when people act collectively to promote economic and social justice, while expanding opportunities for people to increase control over the institutions that influence their lives. By doing so, material changes can be made as well as changes in the relations of power. Improving access to health resources would create positive material changes in the lives of many women who are homeless, by enhancing access to resources like employment and housing. However, if these changes are created with the involvement and direction of women who are homeless, as this study suggests, opportunities are also created which help to increase the ability of women to increase control of their own lives and the programs and services they use.

CHAPTER FOUR

FINDINGS

PART A: IMPACT OF HOMELESSNESS ON THE HEALTH OF WOMEN WHO ARE HOMELESS

> *I guess, typically, statistically, I don't know what the word is they use at the shelter but, you're not weird, you're not bizarre, every woman who's gone through what you've gone through, they all have health issues as a result of everything. It's a fact. So don't feel like you're strange, you know what I mean? So, that was good to hear, and good to know, but by the same token, you sure as heck wish you didn't have so many health issues. I mean, everybody likes to be healthy.* – Sarah.

Sarah would like to be healthy. But, like many of the research participants in my study, she often faces considerable health concerns related to her experience with homelessness. This chapter explores the effects of homelessness on the health of Sarah and women dealing with situations similar to hers. I have grouped the information that emerged through interviews and a focus group into three major themes: (a) symptoms of ill health, (b) stress-producing situations, and (c) personal safety. In the second part of this chapter, I explore how homelessness eased and/or impeded the ability of research participants to access to the social determinants of health.

My study found that homelessness influenced women's health in an all-encompassing fashion. For instance, all but one woman involved in my study described a range of both physical and/or emotional symptoms related to their experience with homelessness. Whether these resulted from homelessness or were pre-existing and exacerbated by the experience is not known; however, significantly, most women reported that homelessness affected their health. And as Jacklyn explained, physical and mental/emotional health are quite interrelated:

> . . . like I said, like, that's my big thing, you cannot treat the physical without treating the mental or emotional. It really actually bugs me the way society ripped them apart. . .

A. Physical Symptoms of Ill Health

Feeling Generally Unwell. In my study, six women explained that they experienced physical symptoms of ill health related to homelessness. A common complaint was feeling generally unwell: Liz described this symptom as feeling "always generally kind of shitty." The elusive nature of this feeling was problematic for some women – they could not pinpoint its exact cause. Anne highlighted this point when she commented:

> *Like, they are real physical ailments, but sometimes you think you're nuts, like you bring it on yourself, or I don't know what you're really thinking, but you just get really sick of not feeling well. A lot of times, it's not even something that you can put your finger on; it's just a general feeling of being unwell.*

Skin Rashes. Three women described developing skin rashes "because of nerves." Anne described that she "kept getting rashes" and as a result, "scratched till I scarred." Sarah also described developing a skin condition – eczema – and her doctor explained that it "comes from nerves." However, she further described that, "stress, antibiotics" and "hormone replacement therapy" were "affecting all kinds of things," including the development of eczema.

Insomnia. Insomnia became a serious concern for Nancy, Jacklyn, and Sarah. In fact, insomnia was found to be quite troubling as Nancy described "sleeplessness" and "restlessness" as her "biggest, biggest problems." For Jacklyn and Sarah, insomnia was complicated by their childcare responsibilities. Jacklyn commented about being prescribed medication to "make me sleep, but then I can't function with my son the next day, so I don't take it." Sarah remarked that since becoming homeless, she cannot "sleep

more than three hours a night." During her experience with homelessness, Sarah lived with her young son in a church building and later in a shelter. She explained that her insomnia was exacerbated by having to share her room with her son:

> *Well, I'll lay there in bed hoping to sleep, but I have to have a television on or I don't sleep at all. And so, with him [her son] right in the same room with me, I didn't feel like I could do that. So, I spent a lot of time, when we were at the shelter, sitting out on the patio. When we were at the church, I just sat out the side of the building in the driveway in the dark, with nothing to do. So, it was terrible. It was very hard that way.*

Communal Living and the Spread of Illness. Communal living proved to be quite unhealthy for Liz and Emily, both of whom experienced street-homelessness. They both spoke about particular physical health difficulties resulting from communal outdoor living, which contributed to the spread of illness throughout the group's members. Liz explained that: "once one person in the group gets sick, we all get sick." Emily described developing bronchitis, and Liz described a very serious incident when she developed "walking pneumonia." She explained: "I almost died because I stopped breathing, so I had to sleep up against the bridge wall."

Illness related to communal living was also prevalent within shelters. Sarah, who lived in a shelter with her son, described how he was "constantly getting colds." She commented that her son's frequent illnesses were due to "living in a communal situation" and because her son already had "asthma and other health issues." Consequently, she explained, "it's inevitable; you're going to be getting sick." Jacklyn also described how living in a shelter environment affected her health:

> *I just find that when I was in the shelter, like you were sick a lot. Because there are so many kids and so many people and you're, everybody's going everywhere. I mean, at one point nobody was allowed in the shelter because we didn't, we didn't know what it was, when I was to see the, to a hospital. . . the doctor said, she goes to me, "It sounds to be like you have influenza B."*

Other Physical Symptoms of Ill Health. Despite the many physical systems of ill health already described, Becky, Anne, and Sarah explained even more ailments related to the experience of homelessness. Becky remembered that her hair began falling out in chunks; Anne explained that her daughter, who was also homeless, "got an ulcer, she's got a bad stomach, she can't digest certain foods." After experiencing harassment from a former spouse, Sarah developed irritable bowel syndrome:

> *. . . we were in court, he was still harassing us, so we were always calling the police and whatever, so by the time we were actually homeless, they were starting to talk about irritable bowel syndrome.*

Mental/Emotional Symptoms of Ill Health

Self-Esteem and Self-Worth. Women in my study, like Anne, lost not only their homes and material possessions, but also a part of themselves. All but one woman involved in my study reported dramatic effects on their mental and emotional health due to homelessness. Most common were low self-esteem and a lack of self-worth. Anne described how losing her home and family affected her sense of self:

> *Like, you have your home and everything. But whenever you lose everything, you lose everything: your self-worth, you lose your home, you lose your physical things. So, it's hard to pick up your feet and do it* [*become housed*]. *So, a lot of people are stuck there.*

For Diana, experiencing enormous barriers when trying to escape homelessness compounded the "shame" of being homeless:

> *It's embarrassing. It's shameful. You feel like a failure. You feel like, what did I do wrong? And then sometimes, it feels like no matter what you do, the world is out to get you. It feels like no matter what you do, you're struggling to find something, you're struggling, you know. Well for me, I'm struggling to find a place to get out of here* [*a shelter*]. *And yet, every time I turn around and there's a possibility, it's shut down by this law or that rule, or you know, this roadblock. There's always something that blocks you. And sometimes you feel like you have*

> *to move heaven and earth just to find one little opening to try and squeeze through.*

Depression. Four women described experiencing depression – deep feelings of dejection and misery – when homeless. Anne explained that becoming homeless was "a very devastating feeling" and that she "was a mess" when she entered a shelter in order to escape an abusive partner. She felt this way because she was "leaving everything I've ever had in my life, everything I worked for, all of my dreams." Jacklyn echoed Anne. She commented that "depression gets really bad, um, to try to rebuild everything. I've lost a hell of a lot." However, Nancy described how depression was also a cause of her homelessness:

> *. . . so I went through a really bad depression, but I'm on the other side right now. But I think it's the depression that keeps me homeless, it's like, I don't care, you know, if I have a roof over my head, I'll still survive.*

Anxiety. Anxiety became a significant symptom of ill health for Anne and Jacklyn when homeless. Anne explained that her "emotions would go up and down" and that she was "emotional all the time." She described this in terms of experiencing anxiety, which she stated was "a total nightmare." Jacklyn explained that not having a home exacerbated an existing anxiety disorder:

> *. . . the more time I spent not having my own place, the worse my anxiety got, the anxiety disorder got really bad.*

Self-Harm. A couple of women described harming themselves while homeless. Jacklyn explained that she "used to be a cutter" but had since stopped. However, she described experiencing difficulty in stopping self-harming habits, even though she is now housed: "It's hard not to go back and start, you know, picking or cutting myself or putting myself down."

Boredom. Boredom, for Nancy and Sarah, far from being banal, contributed to other health concerns and indicated a significant loss of identity. For Nancy, boredom was not a trivial symptom, as she found it was one of her "triggers for addiction." Sarah explained that boredom reflected a change in her role as a homemaker. She described that it was difficult "to spend most of her life as a mother and homemaker" and then "to all of the sudden, to have nothing to fill up your days with everyday." Also, the stress of being bored was exacerbated by her responsibility to her child:

> *So, the worst part was, you don't have your own things around you, you feel really bad for your kids, because my god, they've already been through so much as it is, and then, there's nothing to do. We could have our television with us, in the building that the church had, but there's no cable TV. There was really nothing for him to do, good thing I had a lot of videotapes that I could just grab a box of videotapes, and bring that along for him for something to do when it was dark at night. But, most of the time you spent out and about, you know, filling your day with whatever, and it was being at the shelter was an experience I'm glad I got to have for me, but I wish he wouldn't have had to do it, because it was very stressful.*

B. Stress-Producing Situations

Sarah described homelessness as "scary, scary, scary, really, really scary." Homelessness itself was stressful, and eight women reported that stress was a symptom of their experience with homelessness. This makes stress one of the most widely reported symptoms associated with homelessness in my study.

Homeless with Children. Though homelessness is stressful for those experiencing it on their own, caring for children during such an experience intensifies feelings of stress and ill health. For two women in my study who experienced homelessness with their children, childcare created additional stresses. Sarah described it this way:

> *. . . it just seemed like the harder you tried to make sure that you're staying healthy, because you got kids to look after or whatever, the more stressed out you got, which then affected your health more so.*

Living in a Shelter Environment. Many aspects of shelter life caused stress for the women who used the shelter system. Jacklyn described shelter life as: "hard, it's a hard life to live and that's why a lot of women don't make it through, go back to situations that they left to be homeless." For Diana, merely entering a shelter increased her stress:

> *Just walking through the doors, means already that you're having an overly stressful time in your life. And then you're thrown into a situation with 50 to 80 strangers and you don't know anyone or maybe you know one or two people, you know, from outside. But, yet, it's still an unknown situation, because the population changes so quickly in here, with girls coming and going, you never know who's going to be here from one time to the next. So, every time you walk in the door, it's a possible stressful situation. And you don't know if somebody you have differences of opinion or you two just don't get along. You don't know if they've come in, and signed in, you never know if you're going to walk around the corner and get face to face with trouble. You just don't know. So, it's stressful.*

A major stressful factor was the lack of space in shelters. As Anne explained, shelters caused constant stress, particularly because she felt that there could be little done to reduce the levels of stress as government funding for the shelter was reduced:

> *But everyday, the feeling was that they* [*residents of the shelter*] *would know, hey, there's no room. There would be a lot of anxiety in there, a lot of tension, because there was no room. And the facilitators could do nothing, everything was out of their hands, because I guess it was government cutbacks.*

Jacklyn described similar concerns related to stress, lack of space, and funding cuts in shelters. She felt that lack of space, overcrowding, funding cuts, and staff turnover caused irritability and conflict in the shelter she lived in. Ultimately, it led her to question living in the shelter at all:

> *And there's got to be an easier way to be able to cope for these people, rather than having to live with, like how do you keep yourself together with 20 kids running around in this building, 12 other women, whole bunch of staff changing in and out, and then you know that there's, like I know when I was at the shelter for example, there's major funding cuts, I mean extremely. And then they put two more bedrooms and less staff, more bedrooms, less funding for food, people are getting crabby, nobody wants to do their chores, like you get the people that are*

> *overdoing everything, and then the people that are not doing anything, personality conflicts, cultural conflicts, it's really, it gets to a point where it's like, why am I doing this*?

For Diana, stress and frustration often stemmed from unpredictable shelter rules. She explained that it was difficult to know exactly what the shelters' rules were and that they were applied inconsistently:

> *. . . because of the Ontario Smoke-Free Act, there's no smoking in here. Um, yet, often you can walk down the halls and you smell marijuana or crack, coming from, you just can't tell which room it's coming from, but you can blatantly smell it. So, you know it's being done, the staff knows, they say, "Well, we can't go in a room without just cause.". . . Yet and the same time there was one girl who was kicked out because there was smoke in her room. The smell of smoke was from her room. You know it's things like that that are frustrating.*

Stress was not only felt by residents in shelters, but also experienced by shelter workers. These feelings of stress seemed to spread throughout the shelter, as four women described how residents within shelters felt the stress that the shelter workers were experiencing. By experiencing the stress of the shelter workers, they saw how difficult it was for workers to be both empathetic as well as maintain order within the hectic shelter environment. For instance, Jacklyn described being treated:

> *. . . like you're a baby, and because you're there [in a shelter], that you have no adult sense, of adult responsibility, that part's really frustrating as well. To know that you're 25, 20, 30 [years old] whatever and they're [shelter workers] treating you like you're this baby that doesn't know how to do anything and yeah, they've got to keep things in check. Like, living in a house with say 12 other women and 20 children you gotta have somebody that's gonna crack the whip from time to time.*

However, as five women explained, shelter workers were also seen in positive terms. Diana saw that the majority of workers in the shelter she lived in tried to do a good job; it was just that the nature of the shelter caused difficulties:

> *. . . I'm trying to think of how to word it, without being, rude, because you know, there's bad things but the staff here try. Most of them are really good people,*

> *some of them need a vacation, a very long-term vacation. I think they're getting tired of their job and they need a break. But, most of them are great. Um, just really, they try to be understanding, but it's hard because you try to be understanding and at the same time you've got to be firm.*

Family Breakdown. Many women spoke about stress related to other aspects of their lives. For six women, especially those with children, family breakdown was extremely difficult. The feelings described were very powerful. Emily reported how having Family and Children's Services take her child away had an incredible impact on her life. Someone told her, while street homeless, to "get a life" and she responded: "We did have a life, until authority took it away!" She explained that "A lot of people on the streets can't cope, like, can't cope with having their kid taken away, and have no place to go." Jacklyn also described the extreme stress and anguish she felt when her son was taken by Family and Children's Services after she entered a shelter, due to his behavioural issues:

> *. . . I applied for housing, I had social workers writing me letters left, right and centre. Ontario Housing would not give me an emergency spot until I went through shelter, I said if I go to a shelter, I am going to lose my son because they are not going to put up with his violent and aggressive behaviour. One week to the day I got to the shelter, he was gone. Like, it was hell.*

For Diana, the lack of accessibility in the shelter she lived in contributed to her experience with family breakdown, as she had to temporarily give up custody of her young daughter to a former partner. Diana explained that she had little choice in the matter, since she uses a wheelchair and lacks the assistance she would need to properly care for her child: "in my physical situation, I would need assistance having her here [in the shelter]." This situation was extremely worrying, as she is also enduring a legal battle with this former partner for custody of their daughter. If only Diana had her own home, she would be able to care for her daughter by herself:

> *You know, if I was in a home situation, where I knew I could have access to what I needed, it's different when you're in your own place and it's your own things and you can get around, and you can do what you need to do. I'm not in that situation, so I didn't want custody of her. So, she's with him [her former partner].*

Dealing with Multiple Organizations. Having to deal with multiple organizations, such as social assistance and the legal system, was a cause of stress for a couple of women. Dealing with insensitive social assistance workers was a particular source of frustration for Sarah; it intensified her already negative self-concept:

> *So, yeah, it's a brutal thing. And I know they say what doesn't kill you, makes you stronger, but you know what I mean, it's a pretty intensive trip all the way around when you think you're dealing with police, you're dealing with the courts, you're dealing with welfare, housing, whatever, you're dealing with a lot. You're being bombarded on all sides, by organizations I'd guess you'd say, or what is the word, specific bodies of people. You know what I mean? It's tough.*

C. Personal Safety

Personal safety concerns had intense effects on both the physical and mental/emotional health of most of the women in my study. Eight women described incidents or fears related to personal safety from living on the street, in shelters or in temporary housing in general and from abusive relationships in particular. Moreover, four women described the impact of violence on their health as quite long-term.

Lack of Safety and Security. Concerns related to safety and security were found to be considerably common amongst women who are homeless. In fact, three different ways of experiencing homelessness – street homelessness, 'couch surfing', and living within a shelter – were all associated with safety concerns.

Nancy, Emily, and Liz all had experienced street homelessness at some point in their lives. Also, they all described concerns regarding personal safety during that time. As Emily explained: "When you're on the streets, you learn to watch your back." For

Nancy, safety concerns were quite significant, as she had been assaulted while living on the street. Though traumatic, she also felt that this experience had helped her to eventually escape homelessness:

> *When I was homeless, there was a lot of trauma too. Like I said I was arrested for assault, like people were jumping me, like I got jumped by three girls and I wound up getting an assault charge. And I'm the one that gets arrested, like I said the system just, you know, I look at it as a good thing, those two weeks in jail got me off the street, got me away from those kind of people and it got me up here. You know, some bad things I have to look at as good things.*

In order to negotiate safety concerns, Emily and Liz found that group support was particularly helpful. They both described that having a large group of friends helped them to feel safer, while living on the street. Emily explained, women "are not more likely to get targeted, but if they are alone, they will be vulnerable." To address these safety concerns, Emily described relying on a group of men in order to keep herself out of harm's way. She explained that she knew "a group of men that would protect me. I could go to them if I needed help. There was a group of about five to six men that helped out about four or so women. We ran in a big group."

Living in a shelter was also a precarious situation. Six women described feelings of insecurity or instability while living in a shelter. For instance, Asha described feeling unsafe in that environment. She explained that violence often occurs outside of the shelter, but that it impacts the safety inside the shelter as well. She learned to negotiate her own safety concerns by "stay[ing] away from people, if people are aggressive."

'Couch surfing' can be a significant source of insecurity. Jacklyn was forced into an exploitative situation while temporarily living with a friend and her friend's partner. She experienced different forms of exploitation from both of them, who took advantage

of her when she depended on them for housing. Such exploitation was incredibly trying, given that other housing alternatives were limited:

> *You go to a shelter, you got society shunning you. And then as a woman living in someone else's house, if there's another man, if there's a man in the house, I've talked to other women too and they've all said the same thing, like I've experienced. It's almost like a sexual exploitation, well you want to live in my house, because you have nowhere to go, this is what I expect out of you. . . You get in these situations, where you're damned if you do, you're damned if you don't. You need a roof over your head, you need food in your stomach, you're struggling to make ends meet.*

She experienced not only sexual exploitation, but also financial exploitation. Jacklyn was working during the time and had "a really good boss." Despite a pleasant work environment, Jacklyn's ability to work was compromised by her living situation, as she would have to explain to her employer that she "can't work an extra shift because I have to baby-sit, because the people I live with, if I don't baby-sit for them, my rent goes up." Jacklyn explained that the experience of financial exploitation was quite extensive:

> *I was also being manipulated financially by the girl I thought was my friend. It was like, "Well, I buy groceries all week, you can buy pizza tonight, and you can buy chicken tomorrow night. And you can do this and you can do that, you can babysit." Like, you really get taken advantage of, when you get stuck in a hard spot. And you're just trying to live and you need a roof over your head in winter in Canada, because you do what you got to do, you know, and trying to hold your dignity while you do it.*

Abusive Relationships. Abusive relationships and the trauma associated with them, were common experiences among research participants. Six women spoke of experiencing abusive relationships during their lifetimes, and partner abuse preceded three of the participants' experiences of homelessness. Given that there were no specific questions regarding abuse in the interview, these findings may actually under-represent the prevalence of abuse in the lives of the study's participants. Even so, the effects of this abuse was long-lasting on women's physical and emotional well-being. Anne described

how experiencing abuse dramatically affected her sense of self and her physical health. For her, the very notion of home is problematic; living in an abusive environment was like being homeless:

> *I just couldn't, sometimes I couldn't reach out to go to appointments because I felt such low self-esteem. Feeling sick all the time, because you're feeling you're mentally beat down, so you don't feel well. So you feel there's something wrong with you. When someone says you're, you know, they don't think that you're a good, like somebody's telling you that you're a piece of crap, you start thinking that you are. . . Like, I felt in a way, I was homeless living in that environment because nothing's looked after, I didn't know if I was coming or going, if I would be safe that evening with him or not, when he did come home. . . . So, my mental health was just a mess. Still is. It takes a long time to get back. My physical health went to pot. I just totally, I didn't care about my physical appearance. Like, I started picking my pimples until they were scarred, because I was so mad and angry with myself. So, I had kind of hurt myself, because of what was going on around me.*

PART B: EASING AND IMPEDING HEALTH

The research participants in my study explained that homelessness not only had a direct effect on their health, but also eased/and or impeded their access to health resources - the social determinants of health. The main social determinant of health described was access to health care; other social determinants discussed were housing, healthy food, employment, and social support. Income is another social determinant of health mentioned by women in my study, and it is discussed in this section through its interaction with the other determinants. This section explores how women experienced these issues. Gender-related issues, also strongly linked to many of these determinants, are discussed throughout the section. The two major themes that emerged were (a) access to health care, and (b) other social determinants of health.

A. Access to Health Care

All research participants described different factors that either hindered or facilitated their access to health care. This section explores these factors, which have been arranged thematically as follows: (a) financial barriers, (b) accessing clinical services, and (c) treatment by service providers.

Financial Barriers

Five women described facing significant financial barriers in accessing health care. The most common concern that women spoke about was the high cost of items and services not covered under the Ontario Health Insurance Plan (OHIP), and insufficient health care coverage under social assistance programs. However, the need for public health care was also found to be crucial, as accessibility to it did decrease the cost of health care.

Inadequate Health Related Policies

Prescription Medication. The high cost of prescription medication hindered two women in my study – Diana and Asha - who do not have medical insurance, from receiving the health care that they need. Asha had been homeless for over a decade and had no coverage for prescription drugs; she did not receive assistance from Ontario Works (OW) or any other insurer. In the past, her doctor had provided her with medication free of charge, but had since retired. During our interview, she expressed concern about how she was going to pay for medication in the future, since she had no similar understanding with her new doctor. To make matters worse, she had recently been diagnosed with diabetes, exacerbating her need for medication that she could not afford. Diana also described how paying for medication was a significant concern for herself as

well as her friends. Given her lack of access to medication, she has been resourceful and coped with this situation by caring for her health using homeopathic methods:

> *But, it's like, everyone is supposed to have equal access to health care, regardless; that's not true, they don't. If they did, my friend. . . wouldn't be trying to run around trying to get the money to pay for her prescriptions for her kids. Another woman wouldn't be going crazy because she doesn't have her insulin. You know? And, in my situation, I wouldn't be trying to care for myself homoeopathically, if everyone had the access, they don't. They just don't.*

Dental Care. Sarah and Nancy described the considerable difficulties they experienced associated with getting adequate dental care. Given that OHIP does not cover dental care, Nancy stated that this form of health care is "the biggest challenge I have," due to its cost. She explained: "A tooth extraction is like $150 and they don't do it unless it's like rotten, abscessed, or causing you pain." Meanwhile, Sarah does have dental coverage provided through OW; however, she explained that the coverage provided is insufficient. As a result, the lack of extensive coverage has had a significant impact on her health:

> *. . . I've had dental issues, dental health issues. I had a big hole in my tooth that welfare would not pay to get filled; they'd only pay to pull it out. Well, I only have two molars left here, so what would I chew with then? So, I went along with this big hole in my tooth for years. My gums then would get infected, because the hole started creeping under the gum.*

Transportation Expenses. Travelling to see a doctor or to get medication is typically a necessary component of attaining health care. For a couple of interviewees, paying for the costs associated with such travel was out of their reach and thus, limited their ability to access health care. After the Ontario Disability Support Program (ODSP) no longer supplied a bus pass to Nancy, she was forced to walk to her medical appointments and to pick up her medication. However, she explained that she was often not physically able to walk these distances:

> *. . . I love walking but when I started having problems with my knee, I just can't do it, like when the weather changes it gets like, from my knee to my back, some days I can hardly stand up, some days I can hardly breathe.*

Health Care Expenses Related to Citizenship. Non-citizenship heightened the cost of health care, as it limited the ability to qualify for public health insurance. Diana, an American citizen living temporarily in Canada, is not eligible for OHIP coverage. She spoke at length of her need for health care and how the costs of such care served as a barrier to attaining them:

> *. . . it's difficult for me because I don't have access to the health care system. So my health has not been the greatest. I have to do my health care naturally, you know vitamins and all that, orange juice for colds, vitamin C, one-a-day vitamins, I have to push the vitamins and everything with a healthy diet, because I don't have access to a physician, I can't afford it. Um, I can't afford to go in and get blood work done, I can't afford to go in and get a urinalysis if I get a bladder infection. . . So, for me there is no health care, you know. And, I have access to it, but I don't have the money to pay for it. And if you don't have the money to pay for it, you can't use it. You can't utilize what's there.*

Health Care Expenses Related to Ability. Diana also uses a wheelchair and is in need of catheters when in public; however, she does not always have the means to pay for them. Far from a minor inconvenience, being without a catheter is a major concern for her:

> *I just had to pay $50 for medical supplies yesterday for catheters. And the only reason I had is because I loaned money to one of the girls before and she paid me back. That was the only reason I was able to get the supplies I needed. . . Trying to find an accessible toilet, public accessible toilet, is a load of croak. So, if you're going out and you get hit with the urge, you gotta go, you gotta go right now. So I have to have a catheter when I go out. So, if I would have had to go out between the time that happened, I would have had to use that bag. And I would have had to jury-rig something with tape and you know tampons, pads, padding or something to make it so that the leak wouldn't go all over the place.*

Health Care as an Opportunity Cost. Far from easily accessible, all focus group members of this study agreed that the cost of health care is particularly burdensome.

Nancy remarked, "Anything with health care as a whole is getting really expensive." These were necessary costs in order to ensure one's health, but: "If you take care of yourself physically, you'll end up not being able to pay other bills." Health care is not only costly because of expensive items and travel, but also because by paying for such needs, other needs are left out of reach.

Provision of Public Health Policies

Though many research participants described facing huge financial barriers to accessing health care, three women also explained that coverage for these costs was available, but not always sufficient. Coverage for medical and dental care costs through government policies and programs helped to mitigate the costs of care. Liz explained that she was able to afford prescription medication through OW coverage at a cost of about $2, while Becky spoke about how ODSP covered her prescriptions – once she got on to ODSP in the first place. Initially she had been turned down and then had to reapply.

Nancy explained that her Aboriginal status allowed her to gain dental coverage through Indian Affairs and Northern Affairs Canada (Indian Affairs). She found this coverage to be helpful in reducing costs. However, she also explained how coverage was insufficient:

> *It's been tricky, because a lot of things aren't covered by ODSP or OW. Because if I didn't have my Indian Affairs, I wouldn't have my teeth, like I have a partial plate and Indian Affairs paid for that. But with Indian Affairs, you can only get new dental work every eight or nine years or something like that. So, it's like, if you got it, use it. If you don't got it, then it's a benefit that it would really be good for a person to get.*

Accessing Clinical Services

Hospitals and health care clinics constitute key access points for care in the traditional health care system. Yet, six of the women involved in my study described

facing numerous obstacles to being able to access health care providers in these settings. However, policies and programs within community organizations also played a key role in facilitating women's access to certain clinical health care services.

Inaccessible Health Care Providers

Long Wait Times. Since six women did not initially have regular doctors while homeless, the hospital's emergency room was an important access point for women to get the health care they needed. However, long wait times in the emergency room constituted a barrier to care: "it's stressful enough, whether you're the one sick, or your kid's sick, you know what I mean, to be waiting," Sarah said. She felt that the hospital long wait times amounted to "wasting hours and hours of your time." For Anne, who had gone through the traumatic experiences of leaving her abusive partner and entering a shelter, the long wait times were extraordinarily trying:

> *I was at the hospital, and I needed something to calm me, because I was hyperventilating because I was crying so much. I was just a nervous wreck. I've never been like that in my life. . . . I went to the hospital because I had to get my X-rays done, because I didn't know if they* [*her ribs*] *were bruised or whatnot, because it was a physical fight* [*referring to domestic abuse*]. *And I was traumatized about leaving my home. . . I waited it out; I waited for two hours to talk to somebody. . . .. I just found them walking around, looking at me, and I'm like, geez, my nerves are so bad, and I can't even smoke because I'm in the hospital. Just somebody help me, just somebody talk to me, don't leave me freaking here for too long, you know.*

Sarah also explained that some people are deterred from seeking care because of long wait times:

> *So, a lot of times then you're avoiding, you know what I mean, if you had health care you wouldn't hesitate, you'd make and appointment and you'd go and get it taken care of. But, when you're facing that kind of, you know what I mean, that kind of inconsistent care and that huge, long wait, sometimes you're not going to get health care when you should be going to get health care.*

Difficulty Finding a Regular Health Care Provider. For three research participants, finding a regular doctor was extraordinarily challenging, and they were unable to form strong relationships with one specific doctor. Anne said that the lack of doctors "in the area" stopped her from getting the health care that she needed; her alternative was to use the services of a health care clinic. However, doctors rotate in health clinic settings, so that, as Sarah explained: "you don't have the same person seeing you every time, they don't know anything about you or what you've been through, you know what I mean? It was that part of it that was really, really hard." Anne also experienced frustration in trying to solve this problem by seeing "one specific doctor":

> *I found at times at the health centre that I was going to they wouldn't take appointments, so you could see the same doctor all the time. You couldn't make an appointment for next week, they'd say, "No, call the day before, so you can make the appointment that way.". . . It would really make it hard for us, because I'd like to see the same doctor, but then you call and that doctor is booked already. Or the phone is busy all the time and I can't get in, you have to leave a message. So, that happened to me a few times, and you just want to give up.*

Not being able to form a relationship with one specific doctor was particularly troubling for Diana who had no OHIP coverage. She felt that unnecessary – and financially burdensome – tests had been done on her as a result:

> *When I first got here [to Canada] I couldn't find a doctor, I could not find a physician, a general physician. I was referred to a health clinic, where they have rotating doctors; you never know who you are going to see. So, you can't get to know the doctor, the doctor can't get to know you. So, you go in, and you say, "I'm feeling like this today." The doctor's like, well in the doctor's head, he's going, because if he knows you he's says, "Well I remember once you were feeling like this, and this was the cause, so let's check this." No, you've got a doctor who's never seen you before because you're rotating doctors in a clinic, so you've got to go through the same tests every time. . . So, you have to keep spending money for the same tests, over and over and over, because you can't see one doctor who gets to know you.*

Difficulty Finding a Female Doctor. Anne and Nancy said they were more comfortable and could be more honest about their health concerns with a female doctor, and thus be more likely to get the care they needed. Nancy explained: "I find it easier to talk to her because she's a woman doctor, and it's like I can talk about all the problems that I haven't talked about with the men doctors." Despite her preference, Anne explained that she faced difficulties trying to find a female doctor in Kitchener:

> *. . . at the health centre, I built a comfort with one lady, but she was only a nurse practitioner, so she recommended me to see the doctor there, which was a male. And upon visits, I realized this made me uncomfortable, because I have male issues. And there was a female there, that just now within the last two weeks I've now realized, I'm going to that female doctor and that's my choice and I hope I can stay with her, because that's my comfort zone. But I don't know now, there's so many more people that need doctors. . . .*

Having to Provide an Address. Half of the research participants spoke about the shame and stigma associated with being homeless. In a hospital setting, the stigma of homelessness itself can be a barrier to accessing health care. Having to disclose to hospital staff that they are living in a shelter can be quite an uncomfortable experience for many women who are homeless. Anne felt that people might avoid the problem by not accessing health care services at all:

> *. . . that's really embarrassing, going from the shelter and answering the questions at the front desk, "What's your address?" "I'm at the shelter." That's so awful. People probably avoid that situation too, because they don't want people to know in public. . .*

Community Programs Addressing Health Care Needs

Health Care Provision in Shelters. Shelters themselves can assist residents with attaining their health care needs. For instance, shelters sometimes provide residents with access to medical or clinical workers. Nancy explained that the health care in her shelter

"was mandatory, it was good, because they had the nurse practitioner come in on certain days and you could talk to her about your problems and if she felt you needed to see a doctor then they'd send you to a doctor over there." Also, shelters often maintain relationships with local health clinics, which can furnish access to long-term health care. Because her shelter had a connection with a local health clinic, Jacklyn stated, "I do have a family doctor." For Sarah, such resources were helpful since she would not have to "stress about finding a doctor or going and sitting in one of the urgent cares or the hospital emergency room." Here, Anne describes how the health care provided through a shelter was helpful to her after she left an abusive partner:

> *Coming in and spending their* [*clinical and medical workers*] *time, their afternoons, their mornings, whatever. Just to help listen to the mental health as well, but give advice, to look at your physical body. Because a lot of us would be battered or a lot of us would be neglected. If you're not eating well, if you're not looked after, you don't know where to go. So they had resources with the doctor and staff. Because I didn't have a doctor, moving here. I got hooked up with one right away. So that was recommended by my nurse practitioner. I was just in tears going, "Ah, this is just heaven." I can finally get my health looked after, because I had issues. I had to go to specialists. I'm still going to specialists. I have had injuries that are long-term. They need to be repaired. I have to get my ear repaired, because I had a ruptured eardrum. So, I've got a doctor and the doctor is to get that looked after . . . ..That was at the shelter that was all the connections there. That really, I was amazed at the positive things that way. There are things that they can connect you with that I didn't have to do on my own.*

For Emily, a community-based organization for young mothers helped her gain access to health care. She explained that this organization provided a health plan and some prescription medication coverage, which has been very beneficial for her health. Though she did have to pay some percentage of the medication costs, the coverage itself helped to facilitate her access to medication.

Association with a Government Organization. Though people should not have to become imprisoned to receive the health care that they need, Nancy explained that being

in jail provided her with a key means of attaining health care access. She explained that psychiatrists are "not tough to find," but getting an appropriate referral from a doctor can be, as this necessitates "your doctor to get to know you so she can refer you to the right psychiatrist." She was able to gain access to a psychiatrist through the jail system, and said that this indeed was helpful; however, her access was limited as this particular psychiatrist only worked through the jail system:

> *When I first moved, from another city to here, I lost my psychiatrist in the process, but I was on, um, probation, so they had me seeing me a psychiatrist there that works with the criminals. And, I liked him a lot, I found him really helpful, as far as, as far as somebody who talked to you and talked about what your issues were, I found him very good. Yeah, but unfortunately, he only works with the criminal aspect through, um, the women's jails. . .*

Clinic Policy. Nancy also spoke about how a health clinic policy that prioritized treatment for people with Aboriginal status enabled her to access health care. She had been "travelling back and forth" to her health care provider in another city, after moving to the Kitchener-Waterloo area, but continuing such travel had become increasingly difficult. Because she had "a status card, they [the local health clinic] can't turn me away." This clinic's policy efficiently facilitated her access to care:

> *When I first came to Waterloo it was tough, because I didn't want to switch doctors. But, then when I did, because I thought it would be like a long wait period, and it was for some of the smaller clinics, some of the doctors taking new patients. And with here [the health clinic], you know, I showed them my status card and they booked me right in and transferred my old records and things. So yeah, that was a big help.*

Treatment by Service Providers

Improper treatment from service providers is especially harmful to health, as it can hinder individuals from attaining appropriate health care. Four research participants involved in my study explained they had received improper treatment, when health care

workers treated them rudely and disrespectfully. For instance, medical information was not properly explained or workers did not respect their personal privacy. However, as six participants attested, when treatment is respectful and appropriate, health and health care is greatly improved.

Negative Treatment by Health Care Workers

Unclear Medical Recommendations/Diagnosis. Medical workers sometimes do not explain medical diagnoses and their consequences clearly. Diana said that when she was provided with an unclear explanation by a doctor, she did not request further explanation: "how many people do you know want to look at their doctor and say, I don't understand that?" She feared being perceived negatively by doctors, "especially when it's something, supposedly, relatively simple. Yet, for some reason whatever, you can't understand it." Sarah described a similar concern. She explained that she did not feel comfortable asking her doctor questions because he was not her regular doctor. Though she did assert herself regarding the pain medication needed for her injury, she was left not fully understanding all of the major aspects of the injury and how to treat it:

> *It's like my shoulder happened on the earlier hours on Saturday morning, like 1:30 in the morning, and by Saturday night I realized that there must be something seriously wrong here, like this really hurts. So the next day, I went up here to the urgent care clinic, because I figured it's not going to wait until Monday. . . The man [the doctor] was a nice guy up there, you know, older fella, made a lot of jokes. But again, he was not my doctor, so he didn't explain anything; he didn't put it in a sling. He X-rayed it, yeah, you've got a fractured clavicle, and you know what I mean, blah, blah, blah. At first, he wanted me to just go home and use over-the-counter and just do what you've been doing. And I said, "Are you serious? I have been taking four over-the-counter Tylenol with codeine every two hours and it's not touching the pain, I don't think that's healthy for me, is it?" So, he did give me a prescription then, for thirty Tylenol 3, but again he didn't explain anything about why they don't do anything, you know what I mean?*

Unprotected Privacy. For Sarah and Jacklyn, not having their privacy respected by their doctor amounted to a significant barrier to health care. Such improper treatment caused these women to refuse care from those doctors again. Sarah explained that she had recently left an abusive partner and told her doctor that she had a restraining order against her partner. Even so, the doctor informed her ex-husband of certain private details, breaching her confidentiality and compromising her safety:

> *. . . within probably the first month or so after he [her husband] was arrested and despite having told the receptionist twice and the doctor himself once, that we were not together and no information, he was under a recognizance order the first time, and the second time he was already under a probation order, saying, "Don't tell him anything about us." He breached our confidentiality more than once.*

Jacklyn's doctor also did not respect her personal privacy. Her doctor and her ex-husband were friends. The doctor asked inappropriate and unrelated questions about her former marital relationship. As a result, she too refused to seek this doctor's care:

> *. . . when I left my ex-husband and I ended up in the shelter for the first time, I couldn't see my family doctor, you know why? Because he was a family friend. His family's friend. You know what I mean? I couldn't go see the doctor like that. Because the one time I did, he started reaming because I left him. . . you don't know my life, you're not here to judge, you're here to give me medical treatment. If you're not going to give me compassion, at least just shut up and do your job.*

Inappropriate Reactions. Sarah's ability to attain appropriate health care was hindered by a provider's inappropriate reactions. Though such reactions might not have been intentional, it remained inappropriate, since it caused her to be uneasy and dishonest about her health concerns. She explained that while living in a shelter, she had access to a nurse and a doctor. The nurse had extensive experience working with women who were homeless, but the doctor did not and would often convey non-verbal signs of discomfort. As a result, she too stopped seeing the doctor:

> *But every time she'd [the doctor] ask me, well, how was I doing, I'd have to talk to her and tell her what was going on, why this was happening or that, you know what I mean? She got this awfully pained look on her face, she looked horrified. You know, the nurse can handle the details of what's going on in these women's lives, and I'm sure it pains her just as much, but it's not reflected on her face. So, I started lying to the doctor. Not lying, but just not telling her, because I couldn't bring myself to hurt her like that. You know what I'm saying? I felt like, oh my god I'm hurting this woman so bad by just telling her what I need to tell her. I can't do it, I can't do it, because I don't want her to go home and have nightmares, you know what I mean? I don't know why she looked the way she did, but she didn't stay there [working at the shelter] very long after that. . .*

Judgments by Workers. The stigma of homelessness was found to play a considerable role in the poor treatment that three women received. They described feeling judged by health care workers, simply because they were homeless. Jacklyn explained that "it's really intimidating to go to someone who thinks, who you think, 'A' is better than you, who even acts like they're better than you, because a lot of them are up on their high horse." She further explained: "We're not always dealt the best of hands, and then we're judged for it, and it's beyond our fault." She described one incident in which health care workers had made negative assumptions regarding her intelligence and then responded with shock when she asked thorough questions regarding a treatment plan:

> *And they're going, what a minute, why do you know this stuff? Why? Because, just because I'm homeless doesn't mean I'm illiterate. And even if I was, doesn't mean I'm stupid. Like, you can get the information no matter how you learn. It's just, they, they automatically assume that you're uneducated because you've lived a certain way, and, and half the time, like I'm stumping, stumping everybody, you know?*

Anne also described feeling judged by health care workers. She explained that she felt uncomfortable at her doctor's office because of the negative attitudes expressed by the staff, which she felt was due to her homelessness:

> *. . . I did find that the place that I was going though, I found a little bit of a stigma. I found people do still have an attitude. It might be because of the shelter, it might be because they think some people are abusing the system. The doctor's*

> *office, maybe some people go there more. Because your self-esteem's low, so if you do have something wrong with you, and maybe you've been neglected in the past, because your self-esteem's low, because you've come out of a bad relationship, because you've been homeless, you think maybe more things are wrong with you than there are.*

Jacklyn also related the discrimination she has experienced at the hands of health care workers directly to homelessness when she explained: "People don't see people in a shelter, whether, I don't care whether it's a man or a woman, they don't, you don't get treated like a human being anymore. . . ." One time at a hospital, attitudes towards her changed immediately when she stated that she was living in a shelter:

> *I went in [into the hospital] with this woman. . . and they were treating her like garbage and I was getting pretty upset. And I guess, I stated something about it, like just, "Because she's from the shelter doesn't mean she's whatever, blah, blah, blah." And um, they're like, "Are you a worker there?" And I'm like, "No, I live there too." And as soon as I said that, the attitude and atmosphere changed. It was like, oh here we got two slums, that was how I felt, they didn't really say it. I had one nurse that was actually really good, that was actually the birthing nurse, but um, I just found that, on the most part, it was like, well you must be on drugs, you must be drinking, you must be this, you must be that.*

Due to a having a history of physical and sexual abuse, Jacklyn explained that medical procedures and treatment can be especially difficult for her. So, this made a doctor's utterly inappropriate comments to her even more appalling, and prompted Jacklyn to report him/her. However, the experience also made it difficult for her to continue seeking medical care:

> *It was hard first of all, finding a doctor, then a doctor that is going to for something even like that especially, be patient enough to treat you the way you need to when you're getting something like a pap smear done. Well you know, this is a trigger for me, I could have a flash back, and they're going, "It's not like I'm raping you." And I'm like, I've had a doctor tell me that and. . . I reported him, like I don't take that crap very well, but it's like, it makes it really hard to go to the next doctor.*

Health Care Workers Offering Appropriate Treatment

All health care workers do not treat their patients similarly, and research participants also spoke of many positive experiences with these workers. Support from health care workers – conveyed in their compassion and understanding – helped women get the care needed. However, as Jacklyn explained, women may also need to play an active role in attaining the treatment they deserve.

Empathetic Health Care. Four women described very positive experiences with health care workers who had had experience working with women who are homeless. Jacklyn described feeling "lucky because I've been with, been with doctors that you know, that have worked with a lot of people in the shelter." When she received empathetic care from a nurse, Sarah said she "felt like someone was actually really listening." Also, Anne described the helpful effect of one nurse's empathic approach during the woman's stay in a homeless shelter:

> *When I came, I went to the shelter. And thank goodness they had a nurse come in every Wednesday. Because I felt so bad, I don't know if I would have the strength to mentally, for the first maybe month even, to go to a doctor. Because I felt so down and low self-esteem and so depressed. And because she came in, it made it just so wonderful, because she was so understanding. She dealt with people with in this lifestyle, she was so thorough, she knew exactly what to look for; she made sure that everything was checked. She gave me a total physical and I trusted her because she was a female, because I had male issues. It was really actually, that was one of the nicest things that happened in the beginning.*

Understanding and Adjusting Requirements. Workers who understand the difficult situations many women who are homeless face are often in a position to help facilitate health care access. Asha, who does not have medical insurance, explained how her doctor would provide her with free over-the-counter medication. Also, Diana, who is

without OHIP coverage, had a doctor adjust requirements that would have been incredibly financially burdensome for her:

> *The OB who delivered my daughter, we [her partner and herself] paid, we were supposed to pay him $5000, we were supposed to pay the hospital, the hospital bill also. We were paying the hospital off, and we actually had gotten the hospital off, and we paid him $500 on his bill. And we got a receipt back from his office saying, "Paid in Full." Because he knew our situation, so he only charged us $500 to deliver my daughter instead of $5000. Because I had to have an emergency C-Section.*

Asserting Agency. Research participants described many ways in which they asserted their human agency to create change in their lives. It is important to acknowledge that such assertions of agency occurred within the everyday context of women's lives. For instance, when Sarah received inappropriate treatment from a doctor, she actively stopped being the doctor's patient. Sarah's ability to act created change in her life, as she was able to gain access to appropriate health care by a nurse whom she trusted:

> *I just choose to stick with the nurse, because she has so much experience. I can tell her anything then, so I don't have to pretend like, we're all fine, we're all handling it all just ok.*

Jacklyn also explained that when dealing with service providers, such as health care workers and social service workers, she also asserted her agency in order to receive appropriate care. She explained that her personality and attitude play a significant role when she deals with service providers: "[you] have to be charming, you have to know how to hit people in the heart to get them to give you what you want." By actively developing friendly relationships with service providers, Jacklyn knew them on a more personal basis. As a result, service providers were more likely to respect her opinions:

> *I know all of the people that I work with, I know their children's names, I know where they go to school, I know what they do in their spare time, I've had social workers ask me how I deal with stress.*

Jacklyn further explained how she now negotiates the worker-client relationship, a result of lessons learned from previous negative experiences with service providers:

> *Like, I've been screwed over enough, by a lot of people with their sugar-coating and reading between the lines and all this shit, that you know what? It's time that I reverse it, and I reverse it back on the people that have done it to me... Personally, no, I don't really give a shit that your kid's got a sore throat, but if that's going to get me free bus tickets, you're damned right I'm going to say that I give a shit, you know? If that's going to get me extra visits with my son? If that's going to get me extra support for, for more food in the house? Because I mean, even with the doctors, when I didn't have a drug card, you know? Maybe sometimes I played up my situation...but that's the only way, you've either got to play a victim to get what you want, or you don't get what you want, because if you're aggressive or assertive they seem to get offended. I make it look like it's their idea then, then they're willing to help.*

B. Other Social Determinants of Health

Though my research study was largely focused on health care access, many women involved in this study also described the barriers that they faced when attempting to access other social determinants of health. This section explores the research participant's experiences with these social determinants of health: (a) housing, (b) employment, (c) food, and (d) social support. Significantly, research participants' discussion about factors that eased their access to these social determinants was quite limited and they most often described barriers to the social determinants of health.

Housing

Research participants explained that they face multiple barriers that impede their ability to gain access to affordable and appropriate housing as well as emergency housing.

Lack of Affordable, Appropriate, and Emergency Housing

Cost of Housing. Housing costs can be considerably expensive, and seven research participants spoke of cost as a major factor in attaining housing. The focus group agreed that they typically would only be able to afford to rent a room, at an average cost of about $350/month, and affordable accessible housing options were found to be limited. For Diana, who uses a wheelchair, housing costs are especially burdensome, since she does not qualify for many forms of government assistance due to residency requirements and is in need of an accessible apartment. The barriers to finding an affordable accessible apartment turned out to be insurmountable and as a result, she had been forced to live in a shelter:

> *. . . I can't get an apartment because I can't afford it on my own. Because accessible, financially available housing, without subsidy, it doesn't exist. And I get can't subsidy or government assistance, because I'm not a Canadian citizen. You know. So, therefore I'm kinda caught in between: I can't afford an apartment on my own that I can actually use. I could find a dive, no problem, and I could afford that, no problem. But, it's not accessible, you know, there's no way it would be wheelchair accessible.*

Having to finance transportation expenses was also relevant in the area of housing. Sarah had been able to get community housing in another town, but she lacked the financial resources to travel there. Consequently, she was not able to move into housing and instead, entered the shelter system:

> *. . . I couldn't find a way to get there, because I didn't have the money to take a bus, or whatever other form of transportation that I would have to pay for. And I didn't know anyone with a car that could drive me, and before I heard from any of them again, I was already in a shelter. . .*

Lack of "Women Only" Housing. While many women trying to escape homelessness spoke of the financial barriers in getting housing, limited housing options also posed problems. Anne explained how options for single women were limited in

Kitchener. She explained that the housing available for single women that was available was often not safe:

> *The government does help most people to get their own place, so I started looking for a room. I was terrified of even a rooming house because I didn't want to live with men. I didn't want to live in a drug or alcohol environment. I didn't want to live in any kind of addiction environment. So I didn't know how to go about it, so I'd be phoning people and phoning people. I only found two different houses that rent specifically for women.*

Limited Emergency Housing. Most women involved in my study described difficulties accessing permanent housing. However, as Anne, Sarah, and Becky attested, it was difficult even to access emergency shelters for temporary housing. Such difficulties are extremely problematic for women's health, given that Anne was entering a shelter in order to escape violence:

> *I was in a women's shelter. I got there finally. I tried umpteen times to try to get in and have to phone and see if they'll admit you. They were always booked, they didn't know what to do with me, because there was a shelter here in Kitchener and a shelter miles away in another city. . . they needed more shelters.*

Employment

Employment provides a key means by which to pay for health resources – income. However, discrimination and lack of financial resources were factors limiting the ability of three women to access employment.

Inaccessibility of Employment Opportunities

Emily, Liz, and Nancy all spoke of the considerable difficulties they faced when trying to find and maintain employment. Emily, a lone mother, said that potential employers would often discriminate against her by questioning who would take care of her child when she was working. She commented that "'single mother' is listed under

'achievements' on her résumé," yet potential employers used this identity "against me when applying for jobs."

Having limited financial resources was a key barrier to employment for Liz and Nancy. They have both been diagnosed with having bipolar disorder and they both spoke about the need for employment supports. However, the supports they would need to work effectively – such as specialized headsets to help block out noise, enabling them to concentrate on their work – were too costly. Since they could not afford these supports, their ability to work was greatly inhibited.

Food

The research participants described contrasting views regarding the availability of healthy food. Four women described factors such as financial constraints and limited shelter resources, as negatively influencing their access to healthy foods. However, for Anne, Liz, and Emily, community programs and shelters provided adequate and accessible food options.

Food Insecurity

Cost of Special Diets. A couple of research participants needed to be on a special diet for health purposes. They both explained that financial difficulties poised major challenges for them to pay for the types of food that they need. During the focus group, women explained that changes to OW regulations had made it more difficult to obtain approval for the extra costs of such a diet. Even proving need for a special diet according to OW guidelines has been increasingly difficult. For Nancy, interrelated causes for needing a special diet was one such case. Because she has interrelated causes for needing a special diet, it is incredibly hard to prove her need according to the OW process. In a

related matter, the costs related to Diana's lactose intolerance posed financial burdens to her while living in a shelter:

> *Like, I have to have the lactate and Imodium, because I'm lactose intolerant, I'd say a good 70 to 80 percent of the food here* [*at the shelter*] *is made with milk. If I don't have those pills, I don't eat. What do you do*?

Lack of Healthy Foods in Shelters. Healthy foods can even be hard to find in the shelter environment. Asha gained 30 pounds when she first began living in a shelter. Similarly, Diana mentioned her frustration at the abundance of fatty foods in shelters. She was aware that shelters had limited resources with which to pay for food, yet she maintained that the provision of healthy food should be a priority:

> *. . . every single sandwich I've seen pre-made here, has margarine on it, usually slathered about that high on both sides, that's a healthy diet? My arteries go* [*makes an exploding noise*] *thinking about some of the sandwiches in here. But yet, that's a healthy diet. Um, I understand all of the food is donations, I mean they don't have a steady supply of everything. I think they have a steady supply of some things, but I'm not sure what. But I think between 50 and 80 or 90 percent of the food is donations that's their main staple. If donations went away, everyone in here would starve to death. So, they can't be very selective about what they feed you. But at the same time, they shouldn't just take everything that comes in.*

Diana further explained that the unavailability of healthy food in shelters was also problematic since it created conflict:

> *So they* [*the shelter*] *provide coffee and tea now, but they don't provide juice or milk, except at meal times. And if you try to get extra, to carry you between the two, they yell at you.*

Sarah described similar problems when she lived in a church building. While living there, she did not have access to a kitchen. She explained how she and her son coped with their situation by storing and cooking food – they "lived out of coolers" and they "did have my microwave." She had brought a microwave with her, so that they

"could have something out of a can, hot." Despite her strong coping skills, she also explained how this experience with homelessness limited her ability to eat healthily:

> *And I've always been, you can ask my kids, they hated me for it when they were little but they love me for it now, we eat by the Canada's Food Guide as much as possible. I'm very, it's probably all the guilt instilled in me at a young age, but I try to make sure, even when we're extremely hard up, I do my best to make sure that they're eating healthy. It's not the junk, it's not the crap, it's whatever. So, when you're homeless so you don't have a means of cooking, you're not eating good and that definitely affects your health, I believe.*

Food Security

Access to Food in Shelters and through Community Programs. Not all women described barriers to accessing food. For instance, Liz and Emily both experienced street homelessness and described using community organizations' meal programs. They found no barrier to accessing the programs, and they said that the food provided was sufficient. Also, Anne felt that access to food was adequate in the shelter she lived in. She also noted that the shelter went out of its way to accommodate to the needs of culturally diverse residents and those with special diets:

> *It [food in the shelter] was sufficient. It was help yourself. And then everyday we have a routine where we would have a weekly chore list, and then a weekly cook list, and we'd cook something every week because we'd have a supper hour and we'd all eat together. So that was, it was well looked after in that way. And then we'd go out and buy different ethnic foods if need be, for different people, for different diets, if you had a special diet. They were good that way.*

Social Support

Many women in my study spoke of the need of social support. For three women, some social relationships with professionals and workers negatively affected them, and they did not receive the support they needed. However, research participants also spoke about gaining and maintaining social supports. The shelter system offered an opportunity

for five women to gain access to support from other residents and shelter staff. Also, the support of family and friends outside of the shelter system helped three women access needed health-improving resources. Such support was integral to improving health and one's overall sense of well-being.

Lack of Social Support

Negative Social Relationships. Three women spoke about having negative social relationships with health professionals and service staff. Rather than attaining support from workers, Asha, Jacklyn, and Sarah spoke of how relationships with workers negatively affected them. Asha described workers in the shelter she lived in as "overpowering" and Jacklyn remarked how she had been "labelled left, right and centre" by workers. Jacklyn further explained that her opinions regarding the care of her son were "discounted" by health care workers because she had been negatively labelled as a drug user and alcoholic. Sarah also explained her difficulty with patronizing social assistance workers. Instead of supporting Sarah and helping her to attain the resources she needs, workers conveyed insensitivity. Moreover, Sarah explained that such experiences were common amongst other women she knew:

> *And I feel bad enough already, like you're a loser to be in that situation, that was always one of the things that I heard a lot of women complaining about too, was the insensitivity and the arrogance of I guess is what it is, of them* [social assistance workers], *basically lecturing you on how you should be doing. Well, we're already doing that! Can you suggest anything more, anything new?*

Given Sarah's negative experiences with social assistance workers, she felt that workers should, "actually have to experience what it's like to be on social assistance or to be trying to obtain subsidized housing or living in subsidized housing." By having that experience, workers would better understand the difficulties associated with social

welfare systems. As an example, Sarah explained how one worker conveyed a condescending attitude towards her and did not recognize Sarah's struggle and tenacity:

> *I remember the one woman in particular...she had the nerve to sit there and lecture me on how to save money on food and community cooking, and like what do you think I'm already doing? I'm not even Catholic and the Catholic Church is nice enough to give me a food hamper sometimes when I need one. And I slug food hampers on the bus, to wherever I'm living. I'm not a slouch at saving money; I've had lots of practice. I had a husband who couldn't keep a job because of his temper.*

Possessing a Social Support Network

Supportive Shelter Workers. Five women described how supportive shelter workers helped them to address their health concerns. Such experiences were incredibly positive, as workers helped women to improve their health and feel better about themselves. Jacklyn described how shelter workers "took the extra time. . . to help me deal with stuff." One particular worker helped her to address numerous mental health concerns:

> *. . . this one specific woman at the shelter like there's a lot of them that helped me, but she really, when she found out like I used to be a cutter, I used to be, do drugs, I used to be promiscuous, I used to be a drinker, I used to, you know, I've been through the sexual abuse, mental abuse, emotional abuse, physical abuse, like all over the place, she took the time to actually give a shit and make sure I was alright before she left everyday. We worked on my post-traumatic stress stuff, we worked on some of my stress management of being in there, we worked on, you know, me dealing with the fact, that you know here I've lost everything, I'm also losing my older son, to a system I don't trust.*

Anne also spoke of the incredible significance of worker support while she lived in shelter. Not only did such support help her to address her mental health concerns, but also helped this woman to feel valued after experiencing years of abuse:

> *. . . the facilitators there also helped with my mental self-esteem, saying it's not your fault because that's what I was told for five years, that it's your fault, it's your fault that we're like this, it's your fault that, picking on me all the time. My self-esteem was gone. And the facilitators knew the routine, so they helped me to*

> *realize, going to meetings, and just having them there to talk to, to help them work it through, helped my mental health. So that I could get my shit together, become a person again, because I wasn't a person. I didn't feel like I existed.*

Support from Shelter Residents. While living in a shelter environment, other residents can provide women with social support. In fact, Anne and Diana spoke of the importance of how social networks fostered in shelters helped them cope with stress and the demands of daily life. In Anne's experience, women in the shelter actively coped with their situation by developing mutual-support systems. The women who lived there would try "to support people" by babysitting each other's children and cooking meals, so that they were able to make appointments or go to court. She found that the "group that I was with was very helpful." Also, Diana linked social supports within the shelter directly to her sense of well-being:

> *So, there's a lot of stress, a lot of fear and it's constant, day to day. And you either try not to think about it, or you try to focus your mind on something else. Um, I've been lucky and I've met some really good people here, you know. I've met some really good people here, I've met some people I thought were really good, that weren't. But, I've been lucky in the aspect of, they keep me outside of my mind. They give me, they pull me outside of me, and they won't let me dwell on the pain.*

Support Outside of the Shelter System. For Liz, Kathleen, and Emily, all young women (25 years of age and younger), support provided by family and friends helped them to access resources needed to improve their health. Liz's mother had paid for her prescription medication when she herself could not afford it. Despite being homeless during her adolescence, Kathleen maintained her access to health care, since her mother provided medical insurance: "I was covered under my mom's plan, up until I was like 18 or 19." For Emily, support from a friend enabled her to escape street homelessness. She explained how her "street mom" – a friend's mother - paid her a $25 weekly allowance

when she was homeless. Eventually, Emily's street homelessness ended when her "street mom" allowed Emily to live in her home.

CHAPTER FIVE

DISCUSSION

In this chapter, I examine my research project's findings as they relate to previous studies. First, I elucidate the broad concept of health used in this study in order to understand the health of women who are homeless. Second, I explore the impact of homelessness on women's health. Third, I seek to contribute to existing understandings of the relationship between homelessness and health, by assessing the factors that promote the health of women who are homeless and factors that inhibit it. I situate my findings related to the impeding or facilitating factors within a conceptual framework consisting of four factors: social policy, community resources, living conditions, and social relationships. Fourth, I discuss the relationship between these four factors in order to provide further insights into the relationship between homelessness and women's health. And lastly, I argue that a feminist analysis is needed, in conjunction with social determinants of health theory, in order to explain the health of women who are homeless.

Health as a Broad Concept

Though health can be researched and understood from a variety of perspectives, my study focused on a broad concept of health by using the social determinants of health (SDOH) framework. SDOH addresses the underlying social and economic conditions that influence health (Raphael, 2004). As SDOH proponents argue that factors beyond health care influence the health of individuals and communities, it is a highly appropriate lens through which to study the health of women who are homeless.

I found that the SDOH framework is particularly fitting to research on homelessness and women's health, since it was women who experienced homelessness

who stated that broad social factors strongly influenced their health. I found that housing, employment, income, access to healthy food and health care, as well as social supports were the factors influencing the health of women who are homeless. Significantly, women involved in my study spoke about these factors as relevant in their lives and their health despite the lack of questions (with the exception of health care and housing) regarding these concerns during the interview process.

SDOH is also appropriate when studying homelessness and women's health issues in how it addresses the root causes of health concerns. Traditional approaches to health focus on biomedical and behavioural risk factors, such as cholesterol levels or physical activity. Such factors influence health, but they do not address the underlying causes of ill health. For instance, women in my study spoke about their poor diets. In the traditional approach, unhealthy diets are a significant factor leading to ill health, but the analysis stops there – it remains at a superficial level of understanding. Using the SDOH perspective, my study was able to look at the underlying cause of poor diets amongst the women in my study, and found that it was due to poverty and homelessness. The SDOH perspective thus was particularly suited to the study of women's health and homelessness, due to its relevancy in the lives of women and its provision of a deeper insight into the causes of ill health.

The Impact of Homelessness on Health

Homelessness itself has been found to negatively affect the health of research participants by intensifying health concerns and hindering their ability to cope with health problems. As previous research has found (Ambrosio, Baker, Crowe, & Hardill, 1992), participants in my study did not experience different health problems, but their ability to

cope with health problems was affected by their living and economic conditions, as was the severity of the health problems themselves. For instance, most of the women in the study felt a range of physical and mental/emotional symptoms of ill health, including insomnia, skin rashes, anxiety, and depression along with many other health concerns. Moreover, women saw that illnesses were directly linked to the conditions in which they lived. For those who lived with a group of people on the street, or within shelters, the spread of illness was unavoidable due to the communal environment.

Previous research in the area of women, homelessness, and health tended to focus on women's biology, concentrating on gynaecological concerns, sexual health, and pregnancy (see Ambrosio et al., 1992; Donner, 2002; Ontario Women's Health Council, 2002). The women in my study rarely discussed such concerns. Consequently, I did not find that women's health concerns were directly related to their biological differences from men. Rather, their health concerns were much broader, and I concluded that their concerns should not be understood as necessarily stemming from biological issues.

One of my study's major findings was the impact of stress in the lives of women dealing with homelessness. Previous researchers discussed the significance of stress in the lives of women dealing with homelessness (Ontario Women's Health Council, 2002; Kappel Ramji Consulting Group, 2002; Whitzman, 2006). My study echoes this significance, in finding that women's stress in dealing with homelessness was pervasive and complex, affecting their health and well-being from many different points of origin, such as family breakdown or dealing with multiple organizations (including social assistance organizations and shelters). Such stress can be also understood as having a gendered component, as it is often related to child care and child-rearing, tasks for which

women are typically responsible. Women who were caring for their own children while in the midst of a homeless experience spoke about that stress, and those whose children had been put into care by the state typically spoke feelingly about the stress of losing them.

Most of the women in my study had lived in a shelter at some point. They explained that shelters provided many benefits, such as linkages to health resources, community resources, and supports. However, they also explained that shelters' crowding, constant changes in residents and staff, and internal conflicts made them a very stressful environment in which to live. This finding supports previous research on the health of both men and women living in shelters (Daiski, 2006). Despite the considerable benefits of living in a shelter, and the need for the services shelters provide, living in shelters was particularly stress-inducing and thus, can negatively influence health.

My study also highlighted safety, violence, and abuse issues. Most of the research participants spoke about safety and abuse concerns they had while homeless, or prior to this experience, and spoke of their need for useful services and supports to help them address these issues. Previous research has also noted such concerns (Ambrosio et al., 1992; Dietrich et al., 1999), without necessarily highlighting the long-lasting impact of such experiences for women who are homeless or exploring how women negotiate increasing their own security. My study adds depth to this research by exploring the means through which women who experienced street homelessness negotiated their own safety by relying on men and group support. It also examines the pervasive nature of abuse, noting how such abuse has affected many women's physical, emotional, and mental health over an extended period of time.

Finally, my study found that homelessness affects women's overall sense of health – that is, their physical, mental, and emotional well-being – and for many formerly homeless women, the healing period to recover from their experience would be a lengthy one. Similar to previous research with women who are homeless (Kappel Ramji Consulting Group, 2002; Whitzman, 2006), my study's findings speak to the complexity and interconnectedness of the effects of homelessness on health. I conclude that a multi-faceted understanding of the effects of homelessness is necessary in order to gain a thorough awareness of the health concerns of women who are homeless.

Additions to Existing Knowledge

As previous literature has attested (Dietrich et al., 1999), Kitchener-area research has not effectively gained an understanding of women who are homeless in the City of Kitchener. My findings address this significant gap in local research, adding to existing knowledge on homelessness and women's health research through a greater understanding and acknowledgement of the experiences and health concerns of women who are homeless.

The study of Kitchener-area women illustrates how homelessness has considerable, all-encompassing effects on the health of women, supporting findings from other Canadian cities and towns in previous literature (Ambrosio et al., 1992; Daiski, 2006; Dietrich et al., 1999; Kappel Ramji Consulting Group, 2002; Whitzman, 2006). As Daiski (2006) also found, local shelters were beneficial in that they provided access to services, yet they were also stressful living environments. Such similarity amongst research findings on homelessness issues speaks to a commonality of homeless experiences and health-related concerns, particularly as related to women.

My study also provides additional knowledge to the literature on homelessness and women's health beyond the borders of Kitchener. Rather than finding that women's health concerns stem mainly from their biology (e.g. their gynaecological concerns) (Ambrosio et al., 1992), my study attests to the considerable influence of stress and gendered social roles on women's health. For instance, mothering was a key concern for many of the women in my study. Research participants faced considerable difficulties raising children during a homeless experience, which increased their stress levels and thus, their poor health.

My study also provides additional knowledge regarding the influence of violence and abuse in the lives of women who are homeless. Previous researchers (Ambrosio et al., 1992; Dietrich et al., 1999) have found that violence and abuse have a strong effect on the health of women who are homeless. However, my study speaks to the long-lasting impact of such experiences and the ways in which women negotiate safety while homeless. As a result, my findings add depth to homelessness and women's health research.

Factors That Impede and Promote the Health of Women Who Are Homeless

The research participants in my study mentioned numerous issues that either facilitated or inhibited their health. In this section, I explore the how the health of women who are homeless was impeded and promoted, from the viewpoint of the research participants themselves. After reviewing the literature on this topic, I found that such an analysis has not been previously undertaken. Housing and health research tends to explore the impact of housing (or lack thereof) on health, only rarely considering other social determinants of health (Bryant, 2004). Also, Dunn (2000) found that research

concentrating specifically on homelessness and health predominately focuses on clinical and disease concerns. By contrast, my study relates the lived experience of homelessness to other social determinants of health (such as employment, income, social supports, and access to healthy food and health care). As a result, my study provides significant insight into the lived experiences as well as the social and political factors influencing the health of women who are homeless.

My study also adds depth to the literature by depicting a broad range of impeding and promoting factors influencing the health of women who are homeless. In my analysis, these factors exist within four main categories: (a) social policy, (b) community resources, (c) living conditions, and (d) social relationships. These categories develop a more thorough understanding of the broad social and political factors that have influenced the health of women who are homeless, since they provide insight on how the social environment influences health. They are also similar to those of prior research (Kaplan, 1999); however, they are tailored to fit this study's findings. In order to clearly depict how the impeding and promoting factors fit within these categories, they have been arranged in Table 1.

Table 1.

Impeding and Promoting Health Factors for Women Who Are Homeless in Kitchener, Ontario – Social and Political Context

	Social Policy	**Community Resources**	**Living Conditions**	**Social Relationships**
Impeding Health	Inadequate health-related policies	Inaccessible health care providers Negative treatment by health care providers Food insecurity Inaccessibility of employment opportunities Lack of affordable and appropriate and emergency housing	Lack of safety and security Communal living and the spread of illness	Lack of social support
Promoting Health	Provision of public health policies	Health care providers offering appropriate treatment Community programs addressing health care needs Food security		Possessing a social support network

In this section I discuss each category and the factors each contain that women raised in my research study. Within each category, the factors outline and provide insight into how the health of the research participants has been hindered and/or facilitated, and I compare these findings to previous literature. Though these findings are likely useful and relevant within other communities, they are particularly telling of the situation in Kitchener, Ontario, where the research took place and are thus most appropriately applied to this area.

A. Social Policy

Impeding Health

Inadequate health-related policies. Although Canada upholds a national health care system, many women said they were not able to meet their own key health care needs. They faced considerable financial barriers to accessing health care (Ambrosio et al., 1992; Daiski, 2006; Dietrich et al., 1999; Hausfather, 2005; Hwang, 2001). They were unable to pay for prescription medication, dental care, and related health care needs not covered through the Ontario Health Insurance Plan (OHIP). These findings are not unexpected, as they echo findings from other research (Ambrosio et al.; Ontario Women's Health Council, 2002). Government programs, such as Ontario Disability Support Program (ODSP), Ontario Works (OW), and programs provided by Indian Affairs and Northern Affairs Canada (Indian Affairs) provide access to medical insurance. However, my study, as others have attested (Layton, 2000), found that these programs are insufficient. Some women experienced barriers accessing ODSP – for instance, Becky was initially turned down for coverage and forced to reapply, and Nancy faced the discontinuation of ODSP benefits (such as free bus passes), hindering her ability to even physically reach the care she needed. Also, women explained that the dental care available through OW and Indian Affairs was minimal at best. For example, OW preferred to extract teeth rather than provide more expensive procedures which would retain them. Indian Affairs stringently controlled the amount of available dental coverage.

In order to be eligible for OHIP, Ontario's basic public health care, individuals must meet certain criteria. Generally, to be eligible an individual must be a Canadian citizen, a permanent resident, a landed immigrant or convention refugee, and she must

live in Ontario. A number of other criteria satisfy OHIP eligibility, but many of these require that individuals hold specific documents, such as a work permit (Ministry of Health and Long-Term Care, 2007a). The financial barriers Diana experienced were overwhelming. She was only temporarily staying in Canada due to a custody dispute and was unable to qualify for even basic government programs, because she did not meet the programs' citizenship and residency requirements. Attesting to Diana's resiliency, she coped with her lack of health care by using homeopathy instead of the formal health care services she would have preferred.

Promoting Health

Provision of public health policies. The existence and availability of public health care and government-provided medical and dental insurance helped enable research participants to attain needed health care services. Public hospitals and health clinics as well as health insurance provided through OW, ODSP, and Indian Affairs' programs helped women overcome some of the costs involved with health care. However, many women experienced significant barriers accessing these health care programs, and often lacked the resources to defray specific health care costs not covered through such mechanisms. Yet the existence of these systems did aid women to seek and obtain health care. Consequently, my study found that, overall, the public health system helps promote the health of many women who are homeless.

B. Community Resources

Impeding Health

Inaccessible health care providers. The literature shows that people who are homeless often lack regular health care providers and commonly use hospital services for

health care (Ambrosio et al., 1992; Hwang, 2001). That women who are homeless often use emergency hospital services is illustrated by the six women in my study who initially did not have regular doctors while homeless. Hospitals and health clinics were key points of access to the health care system for them, but gaining access was challenging. For instance, women reported experiencing long wait times. Out of their feelings of shame, Anne felt that women may not want to disclose to hospital staff that they were homeless, and avoid getting their health taken care of altogether. Though health clinics served as an alternative to hospitals, many women found that the clinics' practice of rotating doctors meant they could not form a good working relationship with one health care provider. My study highlights the particularly acute problems women who are homeless experience in Kitchener. Kitchener is a medically under-serviced area (Ministry of Health and Long-Term Care, 2007b). As a result, there are already few doctors servicing Kitchener. Thus, it is likely that women who are homeless there might face significant impediments to accessing regular medical care.

My study's findings also highlight gendered concerns. Past research notes that difficulties accessing and maintaining a regular doctor while homeless cut across gender lines (Ambrosio et al., 1992). However, my research found that some women faced particular difficulties accessing health care providers. Some women were more comfortable being treated by a female doctor, to whom they could speak more honestly about their experiences and concerns. Such a level of comfort helps women to receive the health care that they need. The inability to find a female doctor, within an already under-serviced community, provided an added layer of difficulty.

Negative treatment by health care providers. Health care workers play a significant role in facilitating health care accessibility. In my study, negative treatment by health care providers sometimes impeded the research participant's access to health care. For example, the women reported sometimes encountering health care providers who were unable to clearly diagnose their health issues and offer clear recommendations. Instead, they reacted negatively to women's experiences (when they listened to them at all), passed negative judgments, and did not protect confidentiality. Previous studies echo these findings, in which some health care workers are found to provide poor treatment, and lack knowledge of (and do not display sensitivity to) individuals who are homeless; they also find that health care workers fail to listen to people who are homeless, and act judgmentally towards them (Ambrosio et al., 1992; Daiski, 2005; Ontario Women's Health Council, 2002; Kappel Ramji Consulting Group, 2002). In my study, even when women did have access to health care services, treatment by their providers could pose a significant barrier to appropriate care.

Food insecurity. Many women in the study found their health negatively affected by food insecurity. For example, shelters provided meals but healthy food options were quite limited – one shelter relied on donations for the food it offered, and one research participant described the food available in a shelter as fatty. Women requiring special diets experienced particular difficulties, as recent policy changes had made it more difficult to obtain government assistance (through OW) for special diets. Without such assistance, special diets can be costly to maintain, further aggravating the difficulty. Previous research has also noted these difficulties (Ambrosio et al., 1992; Plumb, 2000). My study adds depth to the issue, in examining the relevance of these current policy

changes. My study's findings suggest that while general food needs may be attended to, the needs of women for healthy or special-diet foods are not still being effectively addressed at a policy or community level.

Inaccessibility of employment opportunities. For three women, employment was often out of reach. Without support for costs associated with employment, women were neither able to attain nor maintain employment. When one woman, a lone mother, attended job interviews, she was asked who would take responsibility for child care while she was at work. She felt judged by this line of questioning. Subsequently, she was turned down for jobs. In another example, some women needed to use headsets or earphones while working, but financial constraints made it impossible to afford them. Restricted access to employment supports negatively affected their ability to work effectively and in their chosen line of work.

A great deal of literature links employment and work conditions to health. On one level, earned income provides the financial resources needed to pay for things like food and housing. However, employment also provides individuals with a sense of worth and access to social networks in the workplace and as such, offers individuals a sense of fulfillment and well-being (Polanyi, 2004). Conversely, studies have shown that unemployment is linked to higher levels of mortality, self-reported physical illness, and increases in anxiety and depression (Wilson & Walker, 1993). Employment is a significant social determinant of health, and access to it would likely improve the health of women who are homeless.

Lack of affordable and appropriate and emergency housing. Housing's high costs have considerably restricted the options of women who are homeless (City of Toronto,

1999). Affordable, appropriate housing is also in short supply. In fact, women in my study were often restricted to renting a room in a boarding house, due to the high cost of housing. Ability and gender concerns complicated the picture further. Diana, who used a wheelchair, could not find physically accessible housing that was affordable, and Anne, a single woman, did not feel comfortable living with men in a boarding house. She found few houses with rooms for women only.

Shelter services were significant to the research participants in this study, as they provided key temporary emergency housing, and in some cases, the means to escape abusive situations. But my study found that emergency shelters in Kitchener often reached capacity. Local research, completed almost a decade ago, noted similar findings (Dietrich et al., 1999), speaking to the prolonged nature of this concern in Kitchener.

Various relationships exist between housing and health. The United Nations has enshrined adequate housing as a basic human right (United Nations, 2007). To satisfy this right, housing has to provide, at a reasonable cost, adequate levels of privacy, space, security, lighting, ventilation, basic infrastructure, and location with regard to work and basic facilities. Housing provides protection from the environment and unsanitary or crowded conditions in poor housing can compromise physical health (Shaw, 2004). Housing and health literature also points to a meaningful dimension of *home*, where housing provides a sense of security, privacy, and a space to establish and maintain social supports, all of which enhance mental and emotional health (Dunn, 2000; Shaw, 2004). Overall, housing, and (more importantly) adequate housing, is a key health-promoting resource.

Promoting Health

Health care providers offering appropriate treatment. Research participants in my study often dealt with many health care workers. These service providers maintain a prominent role in promoting health. Workers who conveyed empathy, compassion, and understanding towards research participants had an extraordinarily positive effect on the mental and physical health of the women, a finding that coincides with previous research (Daiski, 2005). Women were able to relate their physical health symptoms with honesty to such service providers, thus becoming empowered to attend appropriately to their physical health needs; they noted that their mental health improved as a result. Such findings suggest that through compassion, empathy, and understanding, service providers are able to promote the health of women who are homeless. However, as Jacklyn explained, sometimes women must take an active role and negotiate the client-service provider relationship, in order to attain the proper care they deserve. She explained that at times, she exaggerated her circumstances or acted in a charming manner when dealing with service providers, in order to receive proper treatment.

Health care providers provide a range of health-related services. Many of the doctors and nurses that the women in my study went to for treatment worked within the shelter system and/or in local community health care centres, and many were highly effective. A couple of women explained how their doctor would provide free medication or reduce the cost of a significant medical procedure. These doctors understood that the women lacked medical insurance and had limited financial resources. One woman, Anne, had a nurse at a shelter with extensive experience working with women who are homeless. As a result, Anne felt comfortable with the nurse, so could allow her to

conduct a thorough physical examination. These examples illustrate the health benefits of appropriate treatment by health care workers.

Community programs addressing health care needs. According to my study, community programs provide a mediating role in facilitating health care access for the research participants. Shelters that provided in-house access to health care professionals allowed women to bypass barriers they may face in traditional health care settings such as hospitals and clinics. The relationships women were able to develop with health care providers in such settings often extended even after women leave the shelter system. Additionally, some community organizations addressed gaps in health care services by prioritizing the needs of marginalized groups; in one case, an organization for young mothers providing housing and support services also supplied a health plan and some prescription medication insurance for its residents. Such initiatives were essential in order for this woman to attain efficient, effective care. These findings therefore suggest that community programs that address health care needs promoted the health of research participants.

Food security. Many women who were homeless stressed the importance of knowing that they would be able to eat regularly. Community meal programs and shelters provided food, helping greatly with this concern. Though many women noted the lack of nutritional foods in such programs, the fact that food was available at all provided women with security. As such, free food programs within community initiatives promoted the health of the research participants in my study.

Food security is a key social determinant of health which promotes health. Individuals in food-secure households are less likely to suffer from poor health than those

who live in food-insecure households (Tarasuk, 2004). Individuals experiencing food insecurity are more likely to report multiple chronic health conditions, and are more likely to suffer from depression and distress (Vozoris & Tarasuk, 2003). Given the negative mental and physical health outcomes associated with food insecurity, regular access to healthy food is a key health-promoting resource.

C. Living Conditions

Impeding Health

Lack of safety and security. Women who are homeless lack feelings of safety and security (Deming et al., 2002; Dietrich et al., 1999; Frankish, Hwang & Quantz, 2005; Hausfather, 2005; Plumb, 2000). In my study, women reported such feelings, and accompanying extreme stress, to a considerable degree. Women who experienced street homelessness noted that they were concerned about experiencing violence so they had to actively negotiate safety, through group support. Women found that shelters did not provide such safety and security, so that they feared (and felt the accompanying stress of) possible aggression or violence, unclear shelter rules, and lack of space. Heightened and prolonged levels of stress can threaten health in many ways, including a weakening of the immune system, increased insulin resistance, and the development of other biomedical problems later in adulthood (Raphael, 2004). Consequently, stress due to the lack of safety and security can impede health.

Communal living and the spread of illness. My research found that communal living environments – whether street homeless or shelter – promoted the easy spread of illness throughout the group (Daiski, 2005; Frankish et al., 2005; O'Connell, 2004). Poor living conditions, such as large groups of people in a communal living situation, transient

populations, and inadequate ventilation are favourable conditions for promoting the spread of diseases like tuberculosis (TB) (Hwang, 2001). Given that local shelters for women are often full beyond capacity – very much fuller than those for men – the spread of illness due to communal living may be likelier for women (Dietrich et al., 1999). Communal living, typical of many of the research participant's experiences, is itself an impediment to health.

D. Social Relationships

Impeding Health

Lack of Social Support. Research participants in my study experienced negative social relationships with those who are in a position to provide help and assistance – health professionals and service staff. Participants explained that rather than providing support and assistance, workers sometimes labelled them, were overpowering, and were insensitive to their needs. Other studies (Ambrosio et al., 1992; Daiski, 2006; Kappel Ramji Consulting Group, 2002) have also found that disrespectful treatment from workers, such as not being taken seriously and not being listened to, are commonly experienced by people who are homeless.

Research has shown that negative social relationships can impede individual health. Negative relationships can elicit psychological stress and increase the risk for disease (Cohen, 2004). Also, low levels of social support can represent a lesser degree social integration, which can also promote psychological distress (Durden, Hill, Angel, 2007). Consequently, negative social relationships and lacking social support can hinder individual health.

Promoting Health

Possessing a social support network. In my study, social support systems provided a key means by which the research participants improved their overall sense of well-being and safety. As other researchers have found (Ambrosio et al., 1992; Hausfather, 2005), social supports help women to negotiate safety concerns and cope with stress while experiencing homelessness. The women in my study who experienced street homelessness relied on group support to reduce their vulnerability to violence. Three women were able to access money, medical insurance, and housing through supportive family and friends. Women living in shelters explained that other residents provided social support, which afforded women with needed assistance in completing tasks (such as attending appointments) and helped women to avoid focusing on negative emotions. Skilled shelter workers also provided support that helped women deal with their mental health concerns. For example, Diana explained how such support helped her to improve her sense of well-being. Another woman, Jacklyn, described how shelter workers helped her to manage her post-traumatic stress. Clearly, support networks promoted the health of women who experienced homelessness in my study.

Modelling the Health of Women Who Are Homeless

In order to develop a conceptual model of the social and political factors impacting the health of women who are homeless in Kitchener, the four key categories from the discussion have been arranged graphically in Figure 1.

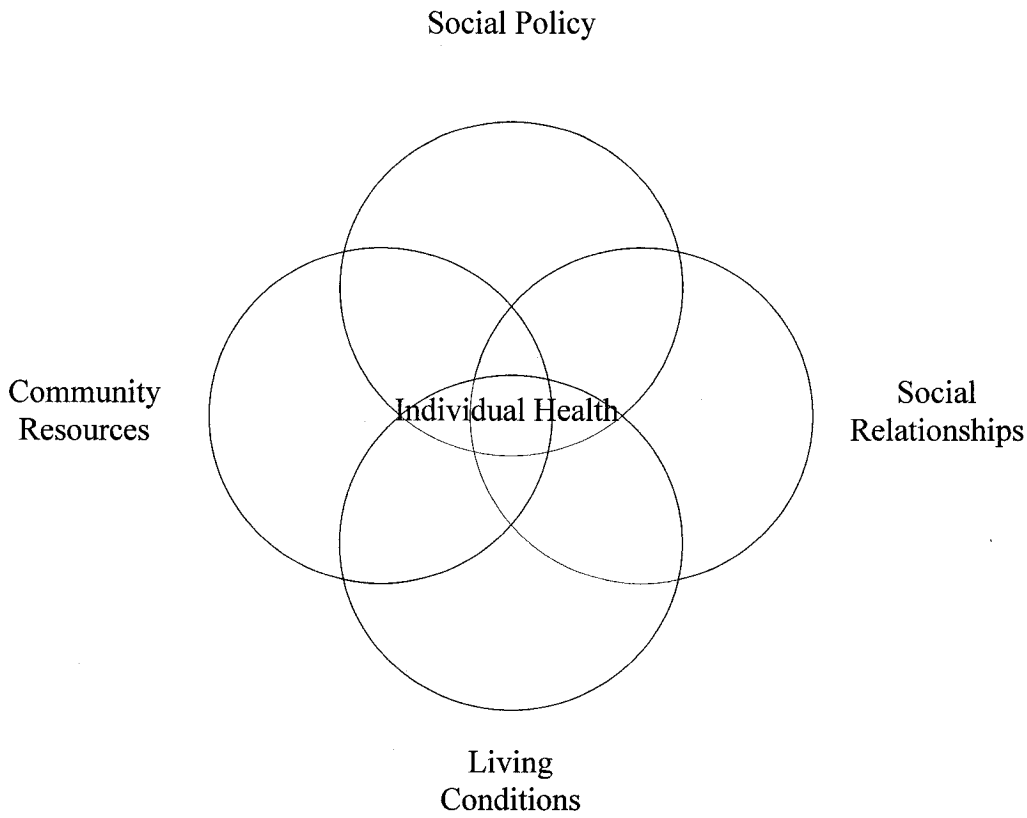

Figure 1. A model for presenting the social and political factors influencing the health of women who are homeless in Kitchener, Ontario.

The determinants of health for individuals, communities, and populations function through many different mechanisms in the social environment. My research has found that social determinants impact the lives of women who are homeless in Kitchener, Ontario, through social policy, community resources, living conditions, and social relationships. Within each of these categories, impeding and facilitating factors influence

health. When any of these categories is felt positively in the lives of women who are homeless, health is promoted. Conversely, when women experience these categories negatively, their health is impeded.

Relationship Between the Key Influences on the Health of Women Who Are Homeless

As discussed above, my study revealed and examined four key spheres affecting the health of women who are homeless. In this section, I explore the relationships between these four key areas, examining related theory and relevant Canadian social policy. I provide further insight into the social and political factors influencing the health of women who are homeless and their plight. I propose that social policies and community resources are linked factors and can both impede and facilitate health. My contribution to the literature in the field of social determinants of health is to draw out the relationship between social relationships, social policies, community resources, and living conditions and to illustrate how all four together influenced the health of the research participants. I argue that social relationships can act as a protective factor for health. However, social relationships are not entirely independent of social policies and community resources; rather, social policies and community resources can also influence social relationships.

Connection between Social Policy and Community Resources

One of the key means by which to understand the influence of policies on health is to examine policies at the community level, for social policies, community resources, and health are linked. For instance, women in my study spoke of the need for adequate income, and access to housing, healthy food, health care and employment. Raphael

(2004) found that these factors strongly influence health and that policy responses are effective in addressing them. In this manner, social policies and community resources are linked. Kaplan (2002) argued that in order to understand the influence of community resources on health an appreciation of the "upstream" policy factors that shape community resources as they influence health is needed. McKinlay and Marceau (2000) developed the concept of "upstream" to refer to macro-level forces, specifically public policy, as influencing population health. Given the stated health needs of women in my study, the "upstream" factors affecting their community's resources and their health are policies affecting the provision of adequate income; affordable, appropriate, and emergency housing; health care; employment; and social assistance.

Community resources inhibit or facilitate health according to the social policy decisions that govern them. The health concerns of many of the women in my study were addressed by community programs and services, including appropriate treatment offered by many service providers, health care services provided by community programs, and meal programs offered through shelters and community services. However, women also indicated the overwhelming inadequacies of community resources, including the lack of affordable, appropriate, and emergency housing, unavailability of healthy food, limited employment opportunities, and barriers to health care access. Community resources can either help or hinder health, depending on their availability and their adequacy at the local level. This finding confirms Frohlich, Ross, and Richmond's (2006) argument that the "causes" of health inequities are proxies for inequities in opportunities, resources, and constraints; and it is in communities that these factors are often experienced. For instance, access to resources like health services or housing can vary across

neighbourhoods, leading some to be healthier than others (Frohlich et al., 2006). This access is determined, in most respects, by social policy.

Influence of the Erosion of Social Policy on Community Resources

In order to provide depth to the connection between social policy and community resources, and also to explain why research participants in my study experienced daunting health impediments related to this relationship, this section seeks to explore the influence of the erosion of social policy on community resources. Everywhere in Canada, and in nearly every major social policy sector, the social safety net is frayed from neglect or tattered from the policy decisions of governments antagonistic at an ideological level to the idea of state-provided social security.

Women in my study spoke of the lack of affordable and appropriate housing in Kitchener. Affordable and appropriate housing is a vital community resource and access to housing is a key social determinant of health. Further, its availability is strongly influenced by government policy. Sufficient levels of government funding and commitment from the government to developing new housing stock, are imperative to the creation and maintenance of some forms of affordable housing, such as social housing.[3]

The limited availability of affordable and appropriate housing in Kitchener is indicative of a national trend. Canadian governments continue to not commit themselves to developing affordable housing. From the mid-1940s to the early-1990s, the federal government maintained various programs to construct affordable housing. However, it withdrew from this role in the 1990s, transferring administration of social housing to

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[3] The term "social housing" is synonymous with the term "community housing" and refers to government- or non-profit-owned and -managed public housing and non-equity co-operative, housing that is resident-owned and -managed (Novac, 2002).

provinces and territories. Most provinces subsequently downloaded this responsibility to municipalities, which have insufficient resources to appropriately address social housing development (Caragata, 2002; Novac, Serge, Eberle, & Brown, 2002). Consequently, Canada has become the only major Western country without a national social housing program (Novac et al. 2002).

Canada's lack of commitment to the creation of affordable housing has a strong relationship with homelessness. An assumption exists that homeless is caused by personal or behavioural issues, as many women within my study were dealing with the trauma of experiencing abusive relationships. However, individual factors alone do not create homelessness (Caragata, 2006). If housing is secure and readily affordable for their income level, many people with personal issues or concerns would not become homeless. However, those who are already vulnerable are often unable to compete in a tight housing market, and as a result, can become homeless (Caragata, 2006). Consequently, housing needs to be equitably distributed. Government could more equitably distribute housing through a housing safety net, which readily provides access to appropriate, accessible and affordable housing (Caragata, 2006).

Temporary emergency housing, in the form of shelters, also constitutes a key housing resource in communities. All but one woman in my study, at one time or another used emergency housing when other housing options were unavailable. Also, three women used temporary emergency housing when escaping abusive relationships. Many community social services, such as shelters, receive funding from governments and all are regulated through government bodies and policies. Therefore, the availability and adequacy of emergency shelters are strongly related to current social policies. I found that

temporary emergency housing is limited in Kitchener and that local shelters lack adequate funding. Consequently, women faced difficulties gaining access to shelters; shelters often reached capacity and felt over-crowded, providing women with little space. Also, though shelters provided food, healthy food options were limited. Consequently, lack of funding for emergency housing options compromised the health of women who, like all people, need safe and appropriate housing options and sufficiently healthy food.

As is the case with affordable and appropriate housing, governments have not adequately addressed the needs of emergency temporary housing in Canada. In 2000, the Progressive Conservative (PC) Ontario government announced it would spend $26 million to address homelessness in Ontario. A large part of this money was geared towards per diems for emergency shelters, domiciliary hostels, and residential care home programs. However, the province's cost-share requirement was 80 percent of shelter expenses, which this new funding did not meet (Novac et al., 2002). In the same year, activists charged the Ontario government harmed women by reducing the budgets of shelters and rape crisis centres by 5 percent (Boyle, 2000). By not adequately funding the emergency services sought by women, particularly those escaping abusive situations, the government promoted unhealthy social conditions for women.

Social assistance for women has been another inadequately addressed policy. Social assistance is an important aspect of the social security net, as it augments inadequate or unavailable labour market solutions, helping individuals to avoid extreme poverty and homelessness (Caragata, 2006). As such, employment opportunities, which are significant health-related community characteristics, are closely related to social assistance policy. My study found that women who are homeless lack employment

opportunities, because they experience discrimination in hiring and because they sometimes lack the ability to pay for supports that would help to maintain employment. Rather than relying on employment, many women in my study had to use social assistance to maintain themselves. Ultimately, policies affecting income support programs such as social assistance figured prominently in their health.

Though women need social assistance to offset the negative effects of an inadequate labour market, Canadian social assistance programs do not provide sufficient support to recipients. The situation in Ontario was especially dire, when, led by the Mike Harris PC government in 1995–2000, the province faced a significant overhaul of its welfare system. The Ontario PC party significantly transformed the welfare system by creating a workfare program, Ontario Works (OW), in which recipients of social assistance are required to participate in community placements or training programs, supposedly to create a "bridge" to permanent employment. The Harris government also tightened eligibility requirements and slashed welfare rates for non-disabled Ontarians by 21.6 percent (Novac et al., 2002). However, workfare has failed nearly completely to create any "bridge" to employment – as of December, 2004, less than 13 percent of OW recipients were attached to the labour force (TD Economics, 2005). Harris's changes to social assistance, which many women in my study faced directly, meant that people did not transfer to employment as intended; instead, they were barely surviving. Moreover, the new Liberal government has failed to restore old social assistance levels, thereby prolonging the financial suffering and impoverished social conditions for those who need such supports.

Introduced in 1997, the Ontario Disability Support Program (ODSP) can be a viable option for women who are homeless to attain social assistance at a slightly higher rate than that offered by OW. However, the definition of disability used by ODSP has been criticized for being too narrow. For instance, it assumes that an individual has one major health condition, rather than several "minor" conditions that interact to cause disablement (Novac et al., 2002; Street Health, 2006). Such deficiencies in the ODSP process can cause significant health concerns for individuals. In my study, Becky experienced a frustrating and time-consuming reapplication process for ODSP, which delayed the receipt of benefits. For Nancy, cutbacks in transportation benefits provided through ODSP meant decreased mobility, which hindered her ability to attend health care appointments. The failure of ODSP to adequately meet the needs of those who require this benefit has resulted in negative social conditions, marked by frustration and limited supports.

Traditional health care services were used by all women in my study. These should be quite accessible, given that public coverage for hospital and physician services is provided to most Canadians (Burke & Silver, 2006). However, women in my study faced long wait lines in hospitals, had difficulties finding doctors, and received poor treatment from health care workers. Such difficulties accessing appropriate health care reflect Canada's failing health care system. Though provinces have primary jurisdiction for health care policy, historically, federal funding and presence were provided, helping to set national standards. However, with decentralization in the 1990s, most of this responsibility was passed to the provinces, leaving significant gaps in funding and guidance (Burke & Silver, 2006). Recently, concerns over the efficiency of the system

have been mounting, with increased calls for privatization, putting the public system at risk. Given that women who are homeless are more likely to experience health concerns, their health is especially made vulnerable due to the eroding health care system (Burke & Silver, 2006).

In sum, social policies direct the provision of many community resources, including housing, health care, employment, and access to income. However, the erosion of social policies, due to federal cuts and, especially since the mid-1990s, due to the measures taken by the Harris government, has created dire conditions in Ontario. Many women in my study still feel the effects of Harris's cuts today. Without adequate assistance, women who are homeless are not able to access the resources needed in order to live healthily. The social security net has tattered so extensively that women who are homeless face an extraordinarily uphill battle when attempting to create healthy living environments, thus hindering their already compromised health.

Influence of Social Policy and Community Resources on Living Conditions and Health

Social policy and community resources have had a significant impact on the living conditions of women involved in my study. Marked by limited housing options and shelter space, these living conditions reflect inadequate social policies and the consequent limited community resources. In a three-way relationship, social policies, community resources, and living conditions, are linked in affecting women's health. Significantly, poor living conditions influenced women's health through both material and psychosocial pathways, two of the main means by which social determinants influence health (Raphael, 2004).

The material conditions of women's living arrangements – poor housing or lacking housing altogether – negatively influenced the physical health of women and their children (Raphael, 2004). For instance, women experienced the spread of illness while living communally in shelters and on the street. For Sarah, the experience negatively influenced her young son's health as well. He already had compromised health before entering a shelter, but the shelter's communal living arrangement exacerbated his poor health and he was frequently ill.

Poor material conditions of life can create psychosocial stresses such as the worry and insecurity derived from social and economic problems (Raphael, 2004; Wilkinson, 1996). For women in my study, street homelessness, "couch surfing," and shelter living led to feelings of insecurity. They worried about being vulnerable to violence on the street, exploited by a friend while living in a friend's home, or living in unstable shelter environments. However, the concept of psychosocial stress does not go far enough in explaining the situation of these women – their experiences went beyond stress and worry. They faced daunting traumatic experiences related to their living conditions while homeless. For instance, Nancy told how she was "jumped" by a group of people on the street, while she was homeless, and was subsequently arrested for being involved in the physical fight. Jacklyn experienced a physically and economically exploitative living situation. Her so-called friends exploited her need for housing, forcing her to babysit, pay for household items, and take part in a sexual relationship. However categorized, all these unhealthy living conditions serve to further the ill health of women who are homeless.

Social Supports as a Protective Factor

My study attests to how social support protects women from the ill health that can result from adverse social policies, community resource issues, and unhealthy living conditions. At the same time, social policies and community resources can have a direct effect on social relationships. The literature in social determinants of health (SDOH) theory tends not to show the connection between social supports, social policy, and community resources in the lives of women who are homeless, in the same way my study does. For instance, Stansfield (2006) posits that social support is influenced mainly by the macro-social environment in the form of social cohesion and, to some extent, the built environment, such as neighbourhoods. However, my approach more fully elucidates the significant role of one aspect of the built environment, namely community resources in the form of shelters, in helping women who are homeless to develop social supports.

Social support can be generally defined as "the functional content of interpersonal relationships" (Israel, Farquhar, Schulz, James, & Parker, 2002, p. 343). Women in my study described social supports as imperative to their feelings of safety and as a valuable coping mechanism during times of duress. These findings coincide with literature that argues social support can be directly associated with one's health. In fact, Link and Phelan (1995) argue that the lack of social supports is a fundamental cause of disease. Their fundamental cause argument is related to one's ability to transport social support from one situation to another. As health-related situations change, if social supports can be maintained, individuals' ability to cope with disease or avoid it altogether will be aided (Link and Phelan, 1995). Consequently, social supports remain as a protective factor in promoting health.

The nature and type of social support may also be significant to one's health. Israel et al. (2002) bring to light the intricacies of social supports in their examination of emotional support (providing love, empathy, and caring) and instrumental support (providing tangible assistance and services that directly help a person). Women in my study spoke of the need for emotional support as a coping mechanism during times of intense duress. Support from friends and shelter workers helped them feel valued and safe, helped them deal with mental health concerns, and distracted them from focusing on their emotional pain.

Instrumental support was also quite beneficial to the women in my study. For Liz, Kathleen, and Emily, family and friends provided tangible support in the form of medical insurance, money, and housing, which the women needed to improve their health. Women coped with shelter living arrangements by sharing responsibility for daily tasks and child care, which provides evidence for the usefulness of group support. This type of arrangement allowed everyone the possibility of attending to her own needs. Though my study did not compare emotional and instrumental support, and I can only hypothesize about a relationship between them. Nevertheless, my findings strongly suggest that women need both instrumental and emotional support. However, I was able to conclude generally that social support acted as a buffer between the women in my study and the negative influences of social policy, community resources, and living conditions.

My study found that social supports likely act as a buffer for negative influences on health. However, such supports are not entirely independent from social policy and community resources, as women spoke about the social support they received in the shelter system from other residents and staff. Though social support does not necessarily

stem from such community resources, the role of shelters as access points to social supports may be an indication of the isolation and marginalization faced by many women who are homeless, as they have limited support resources outside of these institutions.

While social support acts as a protective factor for health, SDOH literature argues that this buffer against negative health influences is not enough to significantly improve the health of individuals and communities. Rather, this literature argues that health differences occur due to the quality of a range of social determinants of health, as experienced in the social environment (Raphael, 2004). My study contributes to SDOH literature a connection between social support, social policy, community resources, and living conditions in the lives of women who are homeless. It refines SDOH literature by suggesting that community resources and social policies are joined and that the quality and access of a range of related determinants – specifically access to housing, employment, health care, income, healthy food, and social supports – need to be addressed in order to effectively address health inequities and create the opportunities women who are homeless require to improve their health.

Need for a Feminist Analysis

The social determinants of health (SDOH) approach to understanding health was particularly useful for my study as it brought to light the underlying social forces which cause the poor health of women who are homeless. Nevertheless, an SDOH approach does not directly connect women's positioning vis-à-vis health to a broader theoretical understanding of their positioning in society. Why is it, precisely, that women who are homeless face forces detrimental to their health and suffer from limited access to health-promoting resources? Is it for little other reason than because they *are* women?

To answer this question, we need a theoretical conception of women's position within society to be used in conjunction with the SDOH approach. This additional layer of analysis will help us to understand why women who are homeless are allocated health resources at inadequate levels and thus, experience poor health.

Feminist theory, which focuses on women's social role in society, is a particularly useful tool to address women's positioning in society and positioning vis-à-vis their health. Moreover, feminist theory and SDOH are strongly related, given their shared emphasis on the social environment and its influence on health. In fact, the feminist health movement of the 1970s rejected the biomedical model, since it focused on reproductive health and reinforced stereotypical images of women, rather than examine social forces like sexism (Reid, 2002). Consequently, both feminism and SDOH point to broader social forces that have shaped women's health and the health care women receive (Armstrong, 2006).

Though gender-based analysis is often used in the SDOH literature (see Ballantyne, 1999; Pederson & Raphael, 2006; Raphael, 2006) after thoroughly researching the literature I have found that, even though some exceptions exist, literature is lacking that makes direct use of feminist theory in an SDOH framework. This means literature that refers to the patriarchy - a key feminist concept and links this concept to a broader theoretical framework in order to explain the relationship between women's particular circumstances and their health. Similarly, in *The Sociology of Health and Medicine*, Annandale (1998) critiques gender and health literature, though not specifically social determinants literature, for also lacking an explicitly feminist orientation. I will add a feminist orientation alongside the SDOH analysis of my findings

that helps explain the ill health of women who are homeless. The purpose of this section is not to re-analyze all of my findings, but rather to bring a much-needed feminist angle to SDOH.

A Brief Overview of Feminist Theory

Feminist theory is an umbrella term for a number of theories regarding women and society. Succinctly, feminism has been defined as: "a movement to end sexism, sexist exploitation, and oppression" (hooks, 2000, p. 1). Feminist theories share a societal analysis that the patriarchy privileges men, by placing the male as the 'standard,' fashioning upon men valued characteristics (such as rationality), and providing men with greater societal and economic power (Annandale, 1998). Feminist theory also holds that in comparison to men, women are constructed as inferior because society ascribes qualities of inferiority to women (Annandale, 1998). As such, women are systematically and structurally discriminated against, whereas men enjoy dominance in the distribution of resources and power (Doyal, 1995). To be sure, all women are not subordinate to all men, as such factors as class, race, age, and ability and disability intersect with gender. However, these categories can also intersect in ways that deepen gender inequality (Brodsky & Day, 1998; Doyal, 1995). For instance, Aboriginal women, immigrant women, visible minority women in Canada, and women with disabilities are more likely to experience poverty than any other women (Brodsky & Day, 1998). And the fact remains that in most societies, the male holds a higher social value than the female (Doyal, 1995).

Feminist Theory, Women Who Are Homeless, and Socially Determined Health

Women's Reduced Opportunities to Attain Community Resources

In my study, I found that women who are homeless face sometimes insurmountable barriers to accessing health-promoting community resources, such as employment, healthy food, housing, and health care. For many women, financial concerns served as one of the major impediments. The expense of the health care they needed, such as dental care, as well as health-related items like housing, and healthy foods, hindered women from obtaining these essential health resources. Gender inequalities in income and wealth mean that men and women have different access to financial resources and that women are especially vulnerable to poverty (Doyal, 2000; Macintyre & Hunt, 1997). Accordingly, women have disadvantaged access to income and, thus, disadvantaged ability to pay for health resources.

Feminist theory can illuminate why women face income and health inequities. Obviously, a key means to gain an income is through employment. Emily, Nancy, and Liz all spoke about their desire to find employment. However, significant financial constraints may continue even with employment, given that women experience the labour force differently than men (Brodsky & Day, 1998). Women continue to earn less than men. The workforce remains segregated, affording lower pay, lower unionization rates, and decreased career mobility opportunities in the 'pink collar' sector jobs, including in "caring" jobs like early childhood educator (Armstrong, 1997; Breitkreuz, 2005; Brodsky & Day, 1998). The lower pay that women receive is reflective of the lesser value people place on women's work – traditionally defined. For instance, caring for people is generally held as less valuable in society than responsibility for money. Accordingly, caregivers are typically paid less for their work than workers in the financial sector

(Armstrong, 1997). As long as women continue to hold employment positions considered less valuable, women's powerlessness is reinforced (Mackinnon, 1989).

Another barrier to women's financial equality is the social assignment of women as unpaid caregivers (Brodsky & Day, 1998). In my study, Jacklyn and Sarah continued to take care of their children while homeless and spoke of the difficulties involved in keeping their children healthy. For Sarah, trying to keep her son eating well was a daunting task, because she did not have access to a kitchen or healthy foods during this period. Jacklyn faced sexual and financial exploitation within a friend's house, which she endured in order to keep herself and her son housed. These situations could have been avoided had women's domestic and childcare roles been valued similarly to employment in the labour force (Doyal, 1995). Though a wage for housework and child care would not necessarily liberate women, economic self-sufficiency would greatly expand women's choices and ability to pay for health resources (hooks, 2000; Mackinnon, 1989). Instead, Jacklyn and Sarah received no payment for their domestic and child care duties, and as a result faced major challenges trying to obtain the financial resources with which to pay for food and housing.

Financial concerns were not the only impediment limiting women's access to health resources. In fact, women in my study cited poor treatment by health care workers was as a significant barrier to accessing appropriate health care and emphasized the stigma of homelessness. For instance, Jacklyn remarked that some hospital workers at a local hospital treated her and a pregnant friend like "slums" when Jacklyn accompanied the friend to her delivery. Also, when Sarah was escaping an abusive husband and had told her doctor that she had a restraining order against him, her doctor breached her

confidentiality by telling her husband of certain private details. Such an act compromised the safety of Sarah and her children.

Feminist analysis adds considerable insight to the poor treatment that women such as Jacklyn and Sarah receive from health care workers. The gendered social role of women means that women not only face economic inequality, but also hold less social and political power than men. The inequality of women who are poor and homeless, as evidenced by the experiences of Jacklyn and Sarah, is especially unjust as they faced not only material deprivation but also discourses that mark them as undeserving and deviant (Reid & Tom, 2006). Accordingly, receiving poor treatment by health care workers is reflective of the inferior social position that women who are homeless hold in society, as women, and as lower-class women.

The Role of Policy: Cuts to Social Policy Further Women's Inequality

Given that women in my study faced disadvantaged access to the health-enhancing social determinants of health, many women were forced to rely on the social safety net to access these health resources. Women spoke of the benefits of social assistance, such as OW and ODSP, in helping to mitigate the costs of health care. Accordingly, governments could help to counterbalance the dynamics of patriarchy that keep women poorer through the creation of more effective social programs and services, such as social assistance, shelters, and affordable housing (Brodsky & Day, 1998).

Though existing social programs help women contend with social and economic inequality, women in my study also noted that these programs are wanting and do not effectively meet their health needs. For example, OW and programs administered through Indian and Northern Affairs provided inadequate medical insurance coverage. Also,

limited affordable, appropriate, and emergency housing and insufficient healthy food in shelters furthered the compromised health of women who are homeless. Such inadequate policies and programs are a reflection of the Canadian government's failure to properly address the health needs of women. Instead of strengthening these programs in order to improve the health of women, governments have made significant cuts to them, such as the drastic reduction of Ontario social assistance rates by 21.6 percent in 1995 (Novac et al., 2002). These patriarchal attempts to dismantle the welfare system are not gender-neutral. They reinforce women's inequality and deprive women who are poor and homeless of access to even the most basic health resources, like food and housing (Brodsky & Day, 1998; hooks, 2000). Consequently, it is even more likely that women's poverty and ill health will continue to increase in the future.

Feminist Addition to Social Determinants of Health of Women who are Homeless

The SDOH approach to understanding health posits that the social, economic, and political resources a society makes available to its members influence the health of individuals and communities (Raphael, 2004). Certain members of society, such as those who are homeless, have less access to health resources and thus experience poor health. In my study, women who are homeless faced sometimes insurmountable barriers trying to attain social health resources. SDOH theory is useful for illuminating the social forces that influence health; however, adding a feminist analysis to SDOH contributes a perspective that helps us understand that the disadvantage women who are homeless face when trying to attain health resources – income, housing, employment, access to healthy food – reflects their extreme material disadvantage and their social position as women, which the patriarchy attempts to ensure is a position of inferiority.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

Conclusion

When I began this research study, I expected to hear that women who are homeless face insurmountable barriers and overwhelming health concerns. Instead, I met 10 strong and resilient women, who spoke at length about the nuances and intricacies of their experiences. Although the extent of their struggle and the oppression they experienced – and continue to experience – are remarkable, in my opinion, many found solace in the assistance and support of those around them.

Too often, research limits itself by focusing on one or two factors, yet the lives of women who have experienced poverty, abuse, discrimination, and homelessness cannot be reduced so simply. By focusing on the social environment in which women lived, I hoped to honour the depth and complexity of their lives. By thus widening the scope, I hoped to gain a more nuanced understanding of how a multitude of social factors contributes to the health of women who are homeless.

My research suggests four major spheres of influence in which the social determinants of health present themselves in the social environment of women in my study: social policy, community resources, living conditions, and social relationships. I propose that social policies and community resources are linked factors and can both impede and facilitate health. Together, they influence living conditions and social supports. However, the sphere of social supports also has an independent component and access to social support serves as a protective factor for health. My findings attest to the complexity within the social environment. Positive health factors in the lives of women

speak to the need for respecting and upholding many aspects of their community – knowledgeable health care workers and healthy public health policy, for example – in order to reduce health inequities. By gaining such an understanding of the social environment, we can address these concerns as stated by women themselves. Ultimately, by seeking out the voices of women who are homeless, a better understanding of their lives and the inequities they face is gained.

SDOH theory proved to be useful as it brought to light the social and political forces that influence health. As a result, I found that health is not merely individual and biomedical; it reflects broad social forces and shows how a society distributes its resources. However, this line of inquiry led me to wonder why it is that women who are homeless, simply because they are women, faced forces detrimental to their health. SDOH theory lacks a broad framework that would link women's position vis-à-vis health to a broader theoretical understanding of their position in society. In order to more fully explain the health of women who are homeless, a feminist orientation in conjunction with SDOH was needed. By doing so, I learned that the inequitable distribution of social and political resources in society, which negatively influences the health of women who are homeless, is not gender-neutral, but is guided by a patriarchal system that attempts to ensure their inferiority.

Recommendations

An important aspect of my study is its practical implications. Women involved in my study spoke about the need to address macro-level as well as immediate and salient needs, at both individual and community levels, in order to promote health. By decreasing health-impeding factors and increasing health-promoting factors, we can help

create healthier communities and enhance the opportunities available for women to improve their health.

I have arranged my study's recommendations according to the four spheres influencing the health of women involved in my study: social policy, community resources, living conditions, and social relationships. In order to address broader societal concerns, I include recommendations based on feminist analysis. Finally, I will discuss future actions and directions for my study.

Social Policy

Ultimately, homelessness and its effects on health can be most adequately addressed through policy responses. In order to promote the health of women who are homeless, such policy responses must be broad. They must include enhancing medicare funding, and also introducing and enhancing a wide array of social and economic policy reforms (Manga, 1987). Though community services may be helpful in alleviating concerns related to homelessness, or even help individuals to escape homelessness, broader policy responses provide a more effective means for ending homelessness (Caragata, 2006). Many researchers and advocates have suggested increasing the availability of affordable housing as a main solution to homelessness, which can be achieved through public policy (City of Toronto, 1999; Layton, 2000).

Many women in this study were unable to afford housing. Given the significance of housing in effectively addressing health concerns related to homelessness, my study's key recommendation is that governments create more housing that is affordable. Through creating low-cost housing and maintaining appropriate increases of affordable units, the affordability concerns of women can be addressed (City of Toronto, 1999). Ultimately,

an equitable distribution of housing, through the creation of a housing safety net, would provide access to safe, affordable and appropriate housing for all members of society. However, women also noted the need for housing appropriate to their needs – affordable accessible housing, for instance. New, affordable housing stock should also include accessible units.

Lack of affordable housing was one of the main concerns of the research participants, yet it is not the only impediment to their health. The inability to pay for services not covered by OHIP – such as dental care and prescription medication – meant that women might not receive the health care they needed. OHIP coverage should be extended to cover prescription drugs and dental care; if not for all people, certainly for those who are unable to pay for these needed services. Liz spoke about the need for increased public prescription insurance, recommending that all prescription medication should be made available free of charge.

Even women who had dental insurance through programs like OW and Indian Affairs felt that they received inadequate dental care. There is a significant need to enhance the coverage provided by programs like OW and Indian Affairs in order to address this health need.

Providing increased dental care insurance through public programs would help women receive the health care they need. However, this change alone would not be enough. For example, there is a significant need to decrease OW's restrictions on funding for special diets. And by extending health and social services to those who do not meet residency requirements, a number of the specific health needs of many women could be addressed.

Even when women are able to obtain housing and acquire adequate coverage for many of their health needs, without sufficient financial resources they may still become homeless, and thus, become subject to homelessness's associated effects on health. In order to address the research participant's income concerns, employment opportunities need to be enhanced, including supportive employment schemes for women who require access to more individual assistance, such as a job coach or funding for specific employment needs (Novac, Serge, Eberle, & Brown, 2002). For instance, Nancy and Liz spoke about the need for earplugs while working, as these devices helped them to concentrate. By providing funding for such items, governments could help women to attain meaningful employment. Moreover, the minimum wage needs to be increased, and the significant cuts to such social assistance programs as unemployment insurance, disability pension, and OW, made by the Ontario PC party under Mike Harris, need to be redressed. Only then would women have the resources not only to obtain housing, but to maintain it (Layton, 2000). Also, these income-related policies and programs would help women to be more able to pay for their needs, such as healthy foods, thereby further enhancing their health.

Finally, my study speaks to the need for a kind of community planning and policy development that would address the concerns of women who are homeless. If a participatory planning and policy development approach were used, women who are homeless could provide their insight and knowledge in order to help create policies which would address their needs. Planning and policy development should be inclusive and democratic (Sandercock, 1998; Wharf Higgins, 1999). It should also respect class, gender, and ethnic concerns in order to address the needs of the marginalized and

oppressed (Sandercock, 1998). By respecting and including women who have experienced homelessness, planners and policymakers could gain a better understanding of their needs and more appropriately address them. Such a participatory process could in itself help to promote empowerment and help remedy inequality.

Community Resources

Community organizations provide vital health-promoting programs and services for women who are homeless. Research participants in my study used shelters and meal programs and they felt that these services were beneficial to their physical, mental, and emotional health. However, they also felt the burdens of lack of space and overworked service providers. As well, the community organizations themselves have suffered considerable funding reductions, which have had a significant impact on the ability of community organizations to provide adequate and accessible services, conduct outreach, or focus on prevention (Dietrich et al., 1999).

In order to address the health needs of women involved in my study, community services need increased funding. Shelters need it to increase available space, which would decrease the stress women experienced due to overcrowding. And, most importantly, women escaping violence would experience shorter waits for an available room. Consequently, increasing funding to shelters would help address many stress-inducing concerns of women who are homeless.

Research also indicates that children of abused women need supports and services too; they too face the long-term consequences related to witnessing and/or experiencing violence. If funding to shelters for abused women and children were increased, preventative services and programs could be set in place to help ensure that violence is

not perpetuated (City of Toronto, 1999). Jacklyn and Anne, echoing these concerns, recommended increased services for children and increased training for youth workers in shelters. Jacklyn commented:

> *Child and youth workers* [*in the shelter she lived in*] *cannot deal with the children in there that are any hard to handle.*

Also, Anne described one resident's daughter, who she felt was not receiving appropriate assistance:

> *I thought I had it bad, this girl has no one to talk to. She's got the issues of people looking at her strangely at school, she has issues of having her poor mom having like, we all have issues. And there was no one for her to talk to.*

She recommended increased space and counselling for children within shelters:

> *And I got back* [*to the shelter*] *and I go, "What do these kids do?" And they go, "Well, we have people downstairs they can talk to." But somebody has to take the initiative to say, "Hey, ok, you and me, I'd like to see you, let's just do a check-in." Because what they have at the shelters, they had a check-in every week, with the ladies. Check in with the children too, say, "Hey, how are you doing?" Another thing that they could have is a homework space for the children, because there was no privacy whatsoever, because the children weren't allowed to be in their room alone. They always had to have a parent with them. And homework was in the dining room. And there's young kids, there's big kids, there's mothers, there's arguing, there's maybe health, there's cooking, there's music. You know what I mean. There's distraction, so homework for the kids, there was no privacy for them either.*

By increasing funding to shelters and to community meal programs, the quality of food available could also be improved. Because shelter and community meals may provide the only food women will eat during the day, these meals should be as nutritious as possible. In order to improve homeless women's access to healthy food, it might be possible for shelters to develop relationships with local food producers (City of Toronto, 1999). Because there are rural as well as urban areas in Waterloo Region, developing such relationships should especially be possible. Regardless of how it is provided, healthy

food needs should be addressed within community services, in order to promote the health of women who are homeless.

Women involved in my study faced many health concerns. The experience of homelessness itself is fraught with precariousness, which greatly affected women's health. Most concerning, these experiences are occurring within the context of a country that has a national health system. Canada devotes a sizeable portion of its economic resources to health care, and provides universal access to insurance coverage for hospital and physician services to all citizens (Burke & Silver, 2006; Evans & Stoddart, 1994). The system is based on the principle of equity and, accordingly, need and not the ability to pay provides the primary determining factor of access and distribution of health care services – in theory (Burke & Silver, 2006). However, a major barrier to access faced by the women in my study was the negative treatment they often received from health care workers. Given that such experiences are common amongst women who are homeless, the health care system requires a major change in attitude, particularly a change in the attitudes health care workers demonstrate towards people who are homeless (Daiski, 2005; 2006).

By treating people who are homeless with dignity and respect, health care workers help people to feel more comfortable in health care settings, thus facilitating their access to health care (Daiski, 2005). I found that workers who had experience working with this population and who were able to convey compassion and understanding towards them helped to promote health. Jacklyn suggested that health care workers should remember that ". . . you're treating a person, not someone homeless, not, not a label." It may be useful to provide training sessions and/or workshops regarding

homelessness-related concerns and specifically addressing discriminatory treatment of people who are homeless. Such training should be provided to a wide range of service providers, including hospital staff, nurses, and doctors, in order to increase their sensitivity to the needs of women who are homeless.

In order to be sensitive to these needs, health care providers might also want to consider developing services geared specifically towards the health needs of women who are homeless. Considering that research participants experienced all-encompassing health concerns, a focus on holistic health might be very useful. The mental, physical, and emotional effects of homelessness could then be addressed in a more effective and efficient manner. Jacklyn particularly felt that such an orientation in the medical field is needed:

> *They're* [*the medical profession*] *not dealing with the whole situation, the medical profession needs to be more open to dealing with all sides of the human being. And that's, that's the only thing I can just keep stressing, that's my biggest thing.*

My study found that women faced barriers accessing health care in hospitals and clinics; to improve care, health care providers should focus on easing these barriers. Even compassionate health care workers will not be able to provide services that promote health if those services are not accessible to women who are homeless. Health care providers could address these barriers to care by increasing medical services in shelters and providing more outreach services for those living on the street. Clinicians have found the outreach approach ideal for ensuring continuity and quality of care for people who are homeless (O'Connell, 2004). Also, providing incentives for female doctors to provide outreach and services in shelters may be needed in order to alleviate the concerns of women who prefer to seek treatment from other women.

My study found that the ill-health effects of homelessness are long-lasting for many of the research participants. For instance, Jacklyn recently moved into an apartment and described being "glad having my own place"; however, there are "times where I feel like I just want to end it." Due to an overwhelming fear of leaving her newly attained home, she recommended that medical outreach would also be useful for people who are formerly homeless:

> *. . . home type of visits for these people, that you know, they've got a home now, they almost get afraid because of whatever they lived through to leave their home. I mean it's a hard place to be, when don't want to leave your house and you need medical treatment, and you, you can't go get it.*

As well as having difficulty accessing traditional health care services, women in my study noted feeling overwhelmed when they dealt with multiple organizations. Shelters could address these needs of women by developing a "community model." Anne particularly recommended this model, since it could provide access to a range of services – including legal and health care services – thereby limiting barriers to access. Such a model might soon develop in the shelter she used to live in:

> *. . . what I'd heard through the shelter, is that they're trying to bring something that's going to bring a whole community resource environment into the shelter. Which will probably take time, but they'll have the police, they'll have everything, all the offices within the shelter, so you don't have to go to hospital, you don't have to cab it to a different counsellor, they'll have everything in there, their own little offices of everything, the domestic violence group, the health group, the mental health groups, everything there, the doctors there, so they can help within, so you don't feel like you're on display . . .*

Anne further explained why this type of model would benefit shelter residents:

> *That [to have a community model in the shelter] would just be beautiful to have it that way, so that everything's in one facility, the resources. Healing would be quicker; society wouldn't be so down on you, on us people that have needed the resources.*

Even though some health care and shelter workers provided inappropriate treatment to women who are homeless, the women in my study also reported that many workers were passionate about their work and provided them with invaluable support and assistance. These workers helped women obtain needed resources and also addressed their many health concerns. However, the workers also faced significant challenges. They felt burdened by stress associated with their work, which the women who needed these services could feel by association. In order to address worker stress and burnout, Lewandowski (2003) argues for an organizational approach, whereby workers, supervisors, and administrators are engaged in dialogue in order to improve work conditions and suggest improvements that could minimize workplace frustration. Shelter residents should also be engaged in this dialogue regarding improvements to the shelter environment, which could help empower residents and provide a more rewarding work environment for workers. Addressing organizational issues with such a collaborative model would provide the added benefit of helping to reduce feelings of isolation and powerlessness (Lewandowski, 2003).

In order to address stress and burnout, I would also suggest honouring workers, perhaps via public ceremonies, for the help that they provide to the community. By such means, workers would be able to reflect on their practice, people in the community would be able to grasp the significance of homelessness in their community, and the contributions workers make in this area would be more visible. Ultimately, paying these workers a wage commensurate with the importance and the difficulty of their job would be a very important way to convey respect for these workers and to encourage their continuing passion for their work.

Finally, my study suggests the significance of and need for health promotion in the community, to address broader social concerns. Health promotion should address the social determinants of health (Robertson, 1998). If this were the focus, health promotion would become politicized. It would then address structural inequalities and propose strategies that could include local economic development. These would address restricted employment opportunities, equitable income distribution, and solutions for gender inequalities, which would specifically address many of the key factors influencing the health of women who are homeless (Robertson, 1998). Health promotion strategies could seek to address community health concerns through broader policy responses. Significantly, health promotion activities should be completed with people in the communities that they are affecting. Recent health promotion literature has drawn attention to this – consulting "'ordinary' people about what *they* think would improve the quality of their lives, and, even more importantly, to act upon their responses" (Lloyd & Lucas, 2005). By working with women who are homeless, health promotion activities would be enhanced by the expert knowledge of women regarding their needs and environment.

Living Conditions

As homelessness had an extensively negative influence on the health of the research participants, living conditions while homeless were found to inhibit health. Women spoke about the immediate need for safety, security, and protection from the spread of illness due to communal living while homeless. Ending homelessness would provide the best means of defence from these concerns. However, addressing immediate

needs is also significant in order to improve women's current circumstances and health status.

Women in my study described feeling a lack of safety and control over their living conditions, and these feelings can influence health. Smith (1994) argues that when "individuals control space and have privacy needs met, feelings of comfort and freedom are possible" (p. 32). These feelings of control and privacy help to bolster health, as individuals can relax and regenerate (Smith, 1994). As such, shelters should address these safety and security concerns, so that women have a sense of control over their living conditions. However, common safety measures like security patrols can concentrate power in the hands of the staff, and thus lead to residents feeling controlled. So, it may be beneficial for residents to have the opportunity to provide input about shelter life and how to improve it, for instance in a formal or informal committee. By doing so, recommendations for improvement would be better suited to the particularities of the specific shelter.

Mechanisms should also be in place for women who are living on the street or in the home of a friend to be as safe and secure as possible. Outreach workers – such as those through the Downtown Street Outreach Program – currently work on Kitchener streets. Continuing programs such as these are a critical first step in addressing the safety needs of women who are living on the street, as outreach workers provide information, and support and enhance safety by de-escalating potentially divisive confrontations (Morgenson, 2007). The provision of information is significant, as women both on the street and those who are "couch surfing" need to know where to go and who to contact if they feel unsafe. Promotion of information regarding helplines (such as that provided

through Women's Crisis Services of Waterloo Region), shelters, and other community resources should be accessible, so that women are assisted with these concerns. There are no easy answers for providing enhanced safety to women in these situations, but knowing about available sources of support and assistance can be beneficial to address safety concerns.

Protecting against the spread of illness is particularly difficult for women living in communal situations. Enhancing funding to shelters in order to increase available shelter space would be beneficial, as it reduces the overcrowding that can spread illness. Also, Liz, who was street homeless, recommended that those who are living on the street be provided with "better access to stuff like blankets" in order to address health concerns. Building on that recommendation, and as previously mentioned, medical outreach on the street may also be helpful. In fact, one study of homeless youth found the use of a mobile health bus particularly useful to address health concerns. The study found that, if help was not available, many young people would avoid seeking it until their health concerns exacerbated extensively and they required emergency care (Ensign & Bell, 2004). By addressing individuals' health and effectively addressing overcrowding in shelters, we could help to restrict the spread of illness and promote the health of women who are homeless.

Social Relationships

A key health-promoting factor revealed in my study is the significance of social support; it can provide safety and access to resources, and promote overall health. Wilkinson (1996) argues that the lack of personal confiding relationships, as well as the absence of involvement in wider social networks and community activities, affects health

negatively. Support systems need to be nurtured and encouraged in order to promote their usefulness among women. Shelters could help develop them by providing informal community building activities for women, encouraging social cohesion within shelters, and helping women to develop friendships. Concerned by the lack of social activity and recreation available in shelters, Diana recommended that shelters provide entertainment:

> *They [shelters] need to provide entertainment, that you know, gives you something to do, besides sit down and complain and harp and snipe. Because you let a woman sit too long in a room all by herself, she's gonna start talking to the walls. You know? And, so they need to provide things that get them out. And, not just a TV, sorry, idiot box don't cover it. Plus the fact that we have one idiot box for how many women? We have one computer for how many women? You know, they need to provide more and I'd like to see maybe a movie night where they show a movie, they put something down in the cafeteria or somewhere, one of the larger rooms, and they just show a movie. Just to provide everyone a chance, you know, provide popcorn.*

Anne also addressed the need for social supports, who spoke of the benefits she felt by developing a mutual support network within a shelter. However, she also noted that at times she felt constrained by this network as she wanted to "help these people, but then I was putting my problems on hold, my issues on hold." For that reason, Anne spoke of the need to enhance the supports available to shelter residents, so that women could more effectively attend to their needs. To address this issue, she suggested increasing the numbers of volunteers working in the shelter:

> *That could be something that could be increased. Having just volunteers of outside, because we were volunteering on the inside of residents, and we're not mentally stable, some of us, there are pressures inside there too, there are chores to do, responsibilities, we have to make sure that the kids are looked after, a lot them have children. You have to keep your child at your side all the time. To have volunteers there, or even volunteers on-call, that are outside, that are maybe students or what not. To say, "Hey, we have somebody that needs somebody, could you help her go up to the hospital, or help her go to her appointments?"*

Within the broader community, the development of more formalized groups could help to improve social supports. For instance, a women's sub-group within the Homelessness Advisory Group would enable women not only to develop friendships, but also to address their needs collectively. Also, within the focus group portion of my study, group members described a gap within services for adults in the Kitchener area. Specifically, they recommended the development of a program, like Reaching Our Outdoor Friends (ROOF), for adults. ROOF is a local organization that provides a range of services including meals, food hampers, laundry facilities, clothing, access to medical care, and housing support in Kitchener. It also provides counselling and life-skills training. However, its programs are solely for youth (ROOF, 2007). Such a broad-based program for adults would be useful in the Kitchener area.

Feminist Contribution to Recommendations

Thus far I have recommended that organizations, services, and policies, be developed or enhanced to address the various health needs of women who are homeless within the four key spheres influencing their health: social policy, community resources, living conditions, and social relationships. Developing or enhancing organizations, services, and policies would allow us to equitably allocate needed health resources, creating the opportunities women need to improve their health. Though these recommendations would benefit women, feminist theorists teach that in themselves these actions would not be enough. The social structure needs to be radically transformed in order for all members of society, including women who are homeless, to have equitable access to health-promoting resources. We must begin this task by raising our

consciousness, in order to first, understand, and then end gender domination and oppression.

SDOH theory holds that social, economic, and political forces shape health. As women who are homeless often lack adequate levels of social, economic, and political power, their health is likely to be poor. Creating an equitable society is the best means by which to create opportunities for women to become healthy. Only in a socially, economically, and politically equitable society would health resources become evenly available to all society's members. Liberal feminists assert that reformist measures can adequately create gender equality. That is, equality can be created through legal means and social reform within the existing structures of society (Annandale, 1998). However, without fundamental change to the patriarchal social structure, rights gained through social reform can be taken away (hooks, 2000). Ultimately, an end to the patriarchy's sexist domination and oppression is needed in order to create equality. Bringing an end to the patriarchy requires radical change, not piecemeal reform (hooks, 2000).

Radical change begins when we become aware of gender oppression. Women have been excluded as active participants from the making of ideology, knowledge, and culture. Women's experiences and ways of knowing the world have not been represented in the organization of society (Smith, 1987). As a result, the perspectives and interests of one gender and one class, to the exclusion of women, are represented as natural and normative (Smith, 1987). Our consciousness must be raised so that we become aware of oppression, in order for us to be able to fight for radical change:

> [An] oppressed group must at once shatter the self-reflecting world which encircles it and, at the same time, project its own image into history. In order to discover its own identity as distinct from that of the oppressor, it has to become

> visible to itself. All revolutionary movements create their own way of seeing. (MacKinnon, 1989, p. 84)

MacKinnon (1989) argues that consciousness-raising is fundamental to feminism, as it allows gender and gender hierarchy to be deconstructed. Rather than being forces we are not able to fully understand, since our consciousness was formed by patriarchal social structures, we have access to them, so we can comprehend them and think of ways to change the nature of patriarchy in our lives (MacKinnon, 1989). However, in order to address multiple and intersecting forms of oppression, we must go further and "examine our lives from the standpoint of gender, race, and class so that we can accurately understand our position within the imperialist white supremacist capitalist patriarchy" (hooks, 2000).

Though consciousness-raising may seem academic in nature or seem to require us to join organizations, it is accessible to everyone. hooks (2000) contends that we can work on ending sexism where we are by educating ourselves and those around us. Moreover, though feminist politics is grounded in a firm set of beliefs, the strategies for change must be varied and speak to people's lives and experiences (hooks, 2000). As such, all members of society have a role in developing strategies for social justice. By raising our consciousness to understand sexist domination and oppression, and developing strategies for changing the social structure, the overarching factors influencing health – social, political, and economic power – can become accessible to, and thus promote the health, of all members of society.

Future Actions and Directions for My Study

I decided to complete a thesis in order to take hold of an opportunity to learn: to learn more about a topic of interest, to learn how to conduct research, and to learn more

about myself. After gaining a better understanding of the Kitchener community, meeting community workers and activists, and most importantly, meeting the women who became involved in this study, my motivation changed. It developed beyond a focus on myself, as I realized my study's significance and relevance to the community and those who live within it. It was this insight that encouraged me to continue my thesis, as there were many times I wanted to quit.

Local research has addressed the concern that studies regarding women who are homeless in Kitchener are lacking (Dietrich, et al., 1999). I learned this first-hand from people in the community. When contacting community workers and activists regarding my study, many people warned me about the difficulties I would face trying to find information. Also, many workers and activists requested a copy of my findings once completed. At this early point in my research, I realized that developing some form of communication for the community based on my thesis would be a necessary component of my project.

In order to gain a better grasp on how to appropriately communicate my findings to the community, I addressed the concern during the focus group portion of my study. The group agreed that a report would be developed, and brainstormed organizations that should receive it. These organizations included: schools, social services, Lang's Farms Villages, the new medical school opening in Kitchener, local faith-based organizations, and the Kitchener Downtown Community Health Centre, as well as all of the organizations in which I advertised my study. Also, group members stated that all participants in the study should receive a copy of the report for themselves.

A community report based on my study is a concrete and practical first step in addressing the concerns of women who are homeless in Kitchener. Not only does it provide information regarding a group of women who are not fully represented in research, but it can also provide a space for women to explain their experiences concerns, and recommendations for change. On a personal level, women who have experienced homelessness in this community can share in these experiences. Hopefully, they can realize that they are not alone (many women in my study spoke of extraordinary isolation and marginalization). On a larger level, my study highlights the positive health benefits of social relationships. The formation of a group for women who have experienced homelessness may be a key means for women not only to address their own marginalization and gain social support but also to collectively develop strategies to fight for social justice that are suited to their needs. As such, I will highlight the recommendation (to create a group for women who are homeless) within my community report, in order to for readers to reflect on this suggestion and if found suitable, to act on it.

By having access to information on the health needs of women who are homeless, community programs, services, and political officials would also be provided with a useful tool, with which to create change in their services and communities in order to acknowledge, respect, and attend to the needs of women who are homeless. By providing the material resources and services that women who are homeless seek, women's severe deprivation can be addressed, thereby helping to create a more just community (Young, 1990). However, officials and service providers cannot be focused merely on material goods and resources, as the distribution of power, recognition, and respect for women

who are homeless must also be addressed in order to improve women's health (Young, 1990). Kitchener needs to find a way to better address these broader issues, in a manner that is fitting to the community. As experts in their own experiences, women who are homeless need to hold a significant role in any discussions for actions taken as a result of this report or any other initiative developed to address their health needs. Participation and inclusion in society are significant conditions for social justice (Young, 1990). It is by promoting participation, social justice, and action that Kitchener – and all communities – can create a healthier community for all of its members, and specifically for women who are homeless.

APPENDIX A:
Poster Advertisement for Study

Are you a woman who has been homeless in Kitchener-Waterloo?

IF YOU are a woman, 16 years old or older, and are homeless or have ever been homeless in Kitchener-Waterloo, you may take part in a research study.

This study is looking into the relationship between women, homelessness and health.

Participants will be paid **$50.00** for an individual interview and **$30.00** for taking part in a focus group.

If you are interested, please contact Christine at:
Phone: (519) 616-9567 or Email:
researchstudyK-W@hotmail.com for more information.

This study is being conducted by a Wilfrid Laurier University, Master's of Social Work student.

APPENDIX B:
Abstract of Study for Advertisement

Research Study:
The Relationship between Women, Homelessness and Health in Kitchener-Waterloo

Poverty is in all nations, communities and neighbourhoods; but, certain groups, like women, are more likely to experience poverty than others, even homelessness. But, there is not a lot of research on homelessness that focuses on women. Some researchers have stated that the reason for this is that women tend to experience homelessness differently than men. For instance, men who are homeless tend to stay in emergency shelters, but women often stay with partners, friends or family for short-term housing. So, many researchers have stated that is more difficult to find women who are homeless, making it harder to study issues related to women and homelessness. But, this research study will focus on women and homelessness, by looking into the relationships between women, homelessness and health in Kitchener-Waterloo. It will hold 8 – 10 individual interviews and one focus group with women who are 16 years old and older, who are homeless, or have ever experienced homelessness in Kitchener-Waterloo. Women who take part in this study will receive $50.00 for their individual interview and $30.00 for being involved in the focus group. Also, this research will try to find out what change women who have been homeless want to see in Kitchener-Waterloo. By doing so, this research hopes to shed some light on these issues that are often left in the dark and provide a voice for women who are homeless that research often overlooks.

For more information on this research study, please contact Christine at:
Phone: (519) 616-9567 or Email: researchstudyK-W@hotmail.com.

This study is being conducted by Christine Paramonczyk who is a Wilfrid Laurier University, Master's of Social Work student and her advisor is Dr. Peter Dunn, Associate Professor of the Faculty of Social Work.

APPENDIX C:
Individual Interview Guide

1. Can you tell me a bit about yourself?

2. Can you tell me what it is/was like being homeless?
   Probe: What was/is the length of time that you experienced homelessness?
   Probe: Did/do you stay in a shelter, on the street, or use another form of accommodation?

3. Can you tell me what your health is like/what your health was like while homeless?
   Probe: Did you have any physical, mental or emotional health concerns when homeless?

4. How are you doing now?

5. What is it like finding and getting health care?
   Probe: How do you find and get health care?
   Probe: Did/do you face difficulties in accessing health care services?
   Probe: Did/do you have difficulties following medical recommendations?

6. Can you tell me what you think would improve your health?
   Probe: Would changes to health care services improve your health? How?
   Probe: Is anything stopping you from getting the health care that you need?
   A. How do you think that could be changed?

7. Is there anything else that you would like to add, or anything that you feel I should have asked?

APPENDIX D:
Focus Group Interview Guide

The focus group will explore the themes developed from the individual interviews. Each theme will be explained and then the following questions will be asked for each:

1. What are your initial reactions?

2. Do you believe that this is accurate? Why?
   If not, how so?

After all of the themes are explored, the focus group will be asked:

1. Is there anything else that you would like to add, or anything that you feel I should have asked?

APPENDIX E:
Participant Consent Form

WILFRID LAURIER UNIVERSITY
INFORMED CONSENT STATEMENT
The Relationship Between Women, Homelessness and Health in Kitchener-Waterloo
[Principal investigator: Christine Paramonczyk (Advisor: Dr. Peter Dunn)]

You are invited to participate in a research study.
The purpose of this study is to examine the relationship between women, homelessness and health in Kitchener-Waterloo. It will also explore the barriers to health care access faced by women who are homeless or have experienced homelessness in Kitchener-Waterloo. Furthermore, it will also explore resolutions to these barriers, as well as the implications of these findings within the context of Kitchener-Waterloo.

The researcher, Christine Paramonczyk, is a Master's of Social Work student at Wilfrid Laurier University. She is completing this research project for her thesis, which is a component of her studies.

INFORMATION

This research study has two steps:

1. The first includes an individual interview, which will take about 1 – 1.5 hours long.
2. The second step is a focus group, comprised of about 8 – 10 women who took part in the individual interview part of the study. The focus group will take about 1 – 2 hours long.

- *Participation in the focus group is optional for any individual interview participant.* However, if you choose to participate in both, it will take approximately 2 – 3.5 hours of your time.

In order to participate in this research study, you must be a women aged 16 and older, who is homeless or has experienced homelessness in Kitchener-Waterloo.

- For this study, homelessness is defined as: "...someone who is sleeping in indoor or outdoor public spaces, using emergency shelters, living in illegal or temporary accommodation and/or relying on family, friends, or acquaintances for short-term housing (often referred to as 'couch surfing'). A person staying for any length of time with family or friends would also be considered homeless, if they did not have their own private space and access key."

RISKS

There is a potential psychological or emotional risk for participants in this research study. Participants will be asked to speak about their experiences with homelessness and health issues. So, there is a risk that participants will speak about emotionally painful experiences which may be traumatizing.

BENEFITS

Participants will be financially compensated for their involvement in this study. Participants will be paid $50.00 for their involvement in the individual interview as well as $30.00 for their involvement in the focus group.

_____

Participant Initials: _____

The goal of this research is to provide an opportunity for women to have a voice in research on the topic of homelessness by speaking about their experiences and opinions. Also, this research is guided by social justice. It will seek to find what changes the participants want to see in relation to homelessness and health and the researcher will be committed to aid in seeking these changes. The focus group phase of the research study also provides an opportunity for women to discuss issues together as well as the possibility that women discuss ways in which they could work together to seek some of the changes that they would like to see in Kitchener-Waterloo.

This research study will also contribute to the scientific community, given a lack of research on the topic of women who are homeless or have experienced homelessness in the Kitchener-Waterloo community.

CONFIDENTIALITY

In order to ensure confidentiality during the conduct of the research, participants will contact the researcher by phone or email, in order to schedule an interview. Any potential participants will be asked what is the most appropriate means of communication (i.e. phone, email, etc) with the researcher, in the event of changing or confirming an interview time. Also, the researcher and participant will discuss an appropriate site in which to conduct the individual interview. For instance, such sites may include a coffee shop, park or another site where the participant feels safe. This will allow for potential participants to protect their identity by choosing a location in which they feel safe. So, the potential participants will be able to protect their anonymity and identity by choosing the means of communication and an individual interview site.

The self-identification process also ensures the protection of the identity of participants. Since participants are asked to self-identify as women who are homeless or have experienced homelessness, the researcher will not be confirming the participant's identity and/or history from another source. Therefore, there is no documentation needed to prove the identity of participants, allowing for participants to protect their identity.

All transcripts will be kept in a secure location and then destroyed once the research is complete. Only the researcher will have access to the data, and only the researcher will be transcribing information from the individual interviews and focus group. The researcher will keep all information from the interviews and the focus group confidential. However, there is a possibility that the researcher's advisor will be asked to assist with data analysis if guidance is needed, during this aspect of the research.

Personal identifiers of the research participants (i.e. names, addresses, etc) from documentation of the research, including the individual interview transcripts, will be omitted. However, it may be difficult for the researcher to remove all of the identifying information from the transcript of the focus group. Yet, if any focus group participant requests a copy of the focus group transcript, the researcher will remove all identifying information from the transcript, before it is circulated. Also, the researcher will not identify any participant in any write-up or presentation from this research.

Since the focus group portion of the study will involve 8-10 research participants who will all hear what each other say, confidentiality of what is said in the focus group cannot be

guaranteed. However, the researcher requests that all members of the focus group keep what they hear confidential and this request will be repeated before the focus group begins.

COMPENSATION

For participating in this study you will receive _$50.00_ for your involvement in the individual interview as well as _$30.00_ for your involvement in the focus group. You may withdraw your participation from this study at any time without consequences. So, if you choose to withdraw from the individual interview, you would still receive $50.00 and if you choose to withdraw from the focus group, you would still receive $30.00.

CONTACT

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study) you may contact the researcher, Christine Paramonczyk, at phone number: (519) 616-9567, or by email at: _researchstudyK-W@hotmail.com_. This project has been reviewed and approved by the University Research Ethics Board at Wilfrid Laurier University. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. Bill Marr, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-0710, extension 2468.

PARTICIPATION

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be returned to you or destroyed. You have the right to omit any question(s)/procedure(s) you choose.

FEEDBACK AND PUBLICATION

There is a possibility that the report developed from this research study will be published in academic journals, books, presented at academic conferences, as well as sent to organizations that have a stated interest in issues related to homelessness and health (i.e. government bodies such as, the City of Waterloo and the City of Kitchener; health care providers, such as Grand River Hospital and Kitchener Downtown Community Health Centre; community groups, such as the Homelessness Advocacy Group, etc.).

A hard copy of your individual interview transcript as well as a transcript of the focus group (if you attend the focus group), will be offered to you. Upon request, it will be sent to you no later than February 2007, in a means decided upon by both the participant and researcher (i.e. mailed to your home).

CONSENT

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study.

Participant's signature_____ Date _____

Investigator's signature_____ Date _____

_____

Participant Initials: _____

USE OF TAPE RECORDER DURING INDIVIDUAL INTERVIEWS

All individual interviews will be tape-recorded or the researcher will take notes during the interview. If you choose not to be tape recorded, the researcher will take notes throughout the interview.

I give permission to be tape recorded during my individual interview (please check ✓).

Yes _____ No _____

Participant's signature_____ Date _____

CONSENT FOR USE OF QUOTATIONS

There is a possibility that quotations from individual interviews as well as the focus group will be used in the final report and/or presentations and publications developed from this research study. In order to protect your confidentiality, all personal identifiers, such as personal names and names of organizations will be omitted. Nevertheless, there is a possibility that your experiences and/or opinions will be identifiable within the quotes used. However, you can participate in this research study without being quoted.

I give permission to be quoted in the final report and/or presentations and publications developed from this research study (please check ✓).

Yes _____ No _____

Participant's signature_____ Date _____

_____

Participant Initials: _____

REFERENCES

Ambrosio, E., Baker, D., Crowe, C., & Hardill, K. (1992). *The Street Health Report: A Study of Health Status and Barriers to Health Care of Homeless Women and Men in the City of Toronto*. Toronto, ON: Street Health.

Annandale, E. (1998). *The Sociology of Health and Medicine: A Critical Introduction.* Cambridge, UK: Polity Press.

Armstrong, P. (1997). The State and Pay Equity: Juggling Similarity and Difference, Meaning, and Structures. In P.M. Evans & G.R. Wekerle (Eds.) *Women and the Canadian Welfare State: Challenges and Change* (pp. 246-268). Toronto: University of Toronto Press.

Armstrong, P. (2006). Gender, Health, and Care. In D. Raphael, T. Bryant, & M. Rioux (Eds.), *Staying Alive: Critical Perspectives on Health, Illness and Health Care* (pp. 287 – 304). Toronto, ON: Canadian Scholar's Press.

Ash, S. (2004, March 2). Manufacturing or education? Kitchener councillors have a week to decide where to invest $180M. *The Kitchener-Waterloo Record*, p. B1.

Ballantyne, P. (1999). The Social Determinants of Health: A Contribution to the Analysis of Gender Differences in Health and Illness. *Scandinavian Journal of Public Health, 27*, 290-295.

Bhavnani, K.K., & Coulson, M. (2005). Transforming Socialist-Feminism: The Challenge of Racism. *Feminist Review, 80*, 87–97.

Bierman, A.S., & Dunn, J.R. (2006). Swimming Upstream: Access, Health Outcomes and the Social Determinants of Health. *Journal of General Internal Medicine, 21*, 99–100.

Boyle, T. (2000, September 28). Tories to get tough on domestic violence. *The Toronto Star.* p. A.01.

Breitkreuz, R.S. (2005). Engendering Citizenship? A Critical Feminist Analysis of Canadian Welfare-to-Work Policies and the Employment Experiences of Lone Mothers. *Journal of Sociology and Social Welfare, 32*(2), 147-165.

Brodsky, G. and Day, S. (1998). *Women and the Equality Deficit: The Impact of Restructuring Canada's Social Programs*. Ottawa: Status of Women Canada.

Brown, J., & Novac, S. (1996). *No Room of Her Own: A Literature Review on Women and Homelessness*. Ottawa, ON: Canada Mortgage and Housing Corporation.

Bryant, T. (2004). Housing and Health. In D. Raphael (Ed.), *Social Determinants of Health: Canadian Perspectives* (pp. 217–232). Toronto, ON: Canadian Scholar's Press.

Bryant, T. (2006). *Towards a New Paradigm for Research on Urban Women's Health.* Toronto, ON: Centre for Research on Inner City Health, St. Michael's Hospital.

Burke, M., & Silver, S. (2006). Universal Health Care: Normative Legacies Adrift. In A. Westhues (Ed.), *Canadian Social Policy: Issues and perspectives* (4th ed., pp. 375–396). Waterloo, ON: Wilfrid Laurier University Press.

Caledon Institute of Social Policy. (1999). *Poverty in Waterloo Region: An Update.* Ottawa, ON: Caledon Institute of Social Policy.

Callaghan, M., Farha, L., & Porter, B. (2002). *Women and Housing in Canada: Barriers to Equality*. Toronto, ON: Centre for Equality Rights in Accommodation. Retrieved February 9, 2007, from www.equalityrights.org/cera/docs/barriers.htm

Canadian Association of Social Workers (CASW). (2005). *Social Work Code of Ethics.* Ottawa, ON: Canadian Association of Social Workers.

Caragata, L. (2006). Housing and Homelessness. In A. Westhues (Ed.), *Canadian Social Policy: Issues and Perspectives* (4th ed., pp. 267–290). Waterloo, ON: Wilfrid Laurier University Press.

Carniol, B. (2000). *Case Critical: Challenging Social Services in Canada* (4th Edition). Toronto, ON: Between the Lines.

Charette, C. (1991). Introduction. In C. Charette (Ed.), *Research Initiatives on Homelessness: International Year of Shelter for the Homeless* (pp. 1–4). Winnipeg, MB: Institute of Urban Studies, University of Winnipeg.

Cheung, A., & Hwang, S.W. (2004). Risk of Death Among Homeless Women: A Cohort Study and Review of the Literature. *Canadian Medical Association Journal, 170,* 1243–1247.

City of Toronto. (1999). *Taking Responsibility for Homelessness: An Action Plan for Toronto*. Toronto, ON: Toronto Mayor's Homelessness Action Task Force, City of Toronto.

Cohen, S. (2004). Social Relationships and Health. *American Psychologist, 59*(8), 676-684.

Corbin, J., & Strauss, A. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, CA: Sage.

Cresswell, J.W. (1998). *Qualitative Inquiry and Research Design: Choosing Among the Five Traditions.* Thousand Oaks, CA: Sage.

Daiski, I. (2005). The Health Bus: Healthcare for Marginalized Populations. *Policy, Politics, & Nursing Practice, 6,* 30–38.

Daiski, I. (2006). Perspectives of Homeless people on their Health and Health Needs Priorities. *Journal of Advanced Nursing, 58*, 273–281.

Deming, A.M., McGoff-Yost, K., & Strozier A.L. (2002). Homeless Addicted Women. In S.L. Ashenberg Straussner & S. Brown (Eds.), *The Handbook of Addiction Treatment for Women* (pp. 451–469). San Francisco, CA: Jossey-Bass.

DePastino, T. (2003). *Citizen Hobo: How a Century of Homelessness Shaped America.* Chicago, IL: University of Chicago Press.

Dietrich, S., Morton-Ninomiya, S., Vandebelt, D., Adams, S., DeSantis, G., & Klassen, A. (1999). *Understanding Homelessness in Waterloo Region: A Backgrounder.* Kitchener, ON: Social Planning Council of Kitchener-Waterloo.

Donner, L. (2002). *Women, Income and Health in Manitoba: An Overview and Ideas for Action.* Winnipeg, MB: Women's Health Centre.

Doyal, L. (1995). *What Makes Women Sick: Gender and the Political Economy of Health.* London, UK: MacMillan.

Doyal, L. (2000). Gender Equity in Health: Debates and Dilemmas. *Social Science and Medicine, 51*, 931- 939.

Dunn, J.R. (2000). Housing and Health Inequalities: Review and Prospects for Research. *Housing Studies, 15*(3), 341–366.

Durden, E.D., Hill, T.D., & Angel, R.J. (2007). Social Demands, Social Supports, and Psychological Distress Among Low-Income Women. *Journal of Social and Personal Relationships, 24*(3), 343–361.

Ehrenreich, B. (2005). What is Socialist Feminism? *Monthly Review, 57*(3), 70–78.

Ensign, J., & Bell, M. (2004). Illness Experiences of Homeless Youth. *Qualitative Health Research, 14*(9), 1239-1254.

Evans, R.G., & Stoddart, G.L. (1994). Producing Health, Consuming Health Care. In R.G. Evans, M.L. Barer, & T.H. Marmor (Eds.), *Why are Some People Healthy and Others Not? The Determinants of Health of Populations* (pp. 27–64). New York, NY: Aldine de Gruyter.

Frankish, C.J., Hwang, S.W., & Quantz, D. (2005). Homelessness and Health in Canada: Research Lessons and Priorities. *Canadian Journal of Public Health, 96*, 23–29.

Frohlich, K.L., Ross, N., Richmond, C. (2006). Health disparities in Canada Today: Some Evidence and a Theoretical Framework. *Health Policy, 79,* 132–143.

Galea, S., Krieger, J., & Schulz, A.J. (2002). Addressing Social Determinants of Health: Community-based Participatory Approaches to Research and Practice. *Health Education & Behaviour, 29*, 287–295.

Harrison, J., & Morton, M. (2001). Regimes of Trustworthiness in Qualitative Research: The Rigors of Reciprocity. *Qualitative Inquiry, 7*, 323–345.

Hart, N. (1985). *The Sociology of Health and Medicine*. Ormskirk, UK: Causeway Press.

Hausfather, N. (2006). *"You can't understand it until you go through it": A Handbook about Homelessness in Kitchener-Waterloo*. Kitchener, ON: Kitchener Downtown Community Health Centre.

Holmstrom, N. (2002). Introduction. In N. Holmstrom (Ed.). *The Socialist Feminist Project: A Contemporary Reader in Theory and Politics* (pp. 1-13). New York, NY: Monthly Review Press.

Holmstrom, N. (2003). The Socialist Feminist Project. *Monthly Review, 54*(10) 38–48.

hooks, b. (2000). *Feminism is for Everybody: Passionate Politics*. Cambridge, MA: South End Press.

Hwang, S.W. (2001). Homelessness and Health. *Canadian Medical Association Journal, 164*, 229–233.

Irwin, A., Valentine, N., Brown, C., Loewenson, R., Solar, O., Brown, H., Koller, T., & Vega, J. (2006). The Commission on Social Determinants of Health: Tackling the Social Roots of Health Inequities. *PLOS Medicine, 3*, 749–751.

Israel, B.A., Farquhar, S.A., Schulz, J.A., James, S.A., & Parker, E.A. (2002) The Relationship Between Social Support, Stress, and Health Among Women on Detroit's East Side. *Health Education & Behavior, 29* (3), 342-360.

Kaplan G. (1999). What is the Role of the Social Environment in Understanding Inequalities in Health? *Annals of New York Academy of Sciences, 896*, 116–119.

Kappel Ramji Consulting Group. (2002). *Common Occurrence: The Impact of Homelessness on Women's Health. Phase II: Community Based Action Research: Final Report.* Toronto, ON, Sistering: A Woman's Place.

Khosla, P. (2003). *If Low Income Women of Colour Counted in Toronto.* Toronto, ON: Community Social Planning Council of Toronto.

Kidd, S.A., & Kral, M.J. (2005). Practicing Participatory Action Research. *Journal of Counseling Psychology, 52*, 187–195.

Layton, J. (2000). *Homelessness: The Making and Unmaking of a Crisis.* Toronto, ON: Penguin Books.

Lebowitz, M. (2007). New Wings for Socialism. *Monthly Review, 58*(11), 34-41.

Lenon, S. (2000). Living on the Edge: Women, Poverty and Homelessness in Canada. *Canadian Women's Studies, 20*, 125.

Lewandowski. C.A. (2003). Organizational Factors Contributing to Worker Frustration: The Precursor to Burnout. *Journal of Sociology & Social Welfare, 30*, 175.

Lloyd, B., & Lucas, K. (2005). *Health Promotion: Evidence and Experience*. London, UK: Sage.

Lowry, F. (1996). Impact of Health Care Adds to the Social Costs of Homelessness, MDs Say. *Canadian Medical Association Journal, 155*(2), 1737-1739.

Macintyre, S., & Hunt, K. (1997). Socioeconomic Position, Gender & Health: How Do They Interact? *Journal of Health Psychology, 2*(3), 315–334.

MacKinnon, C.A. (1989). *Toward a Feminist Theory of the State*. Cambridge, MA: Harvard University Press.

Maguire, P. (1987). *Doing Participatory Research: A Feminist Approach*. Amherst, MA: Centre for International Education, University of Massachusetts.

Manga, P. (1987). Equality of Access and Inequalities in Health Status: Policy Implications of a Paradox. In D. Coburn, C. D'Arcy, P. New, & G. Torrance (Eds.), *Health and Canadian society: Sociological Perspectives* (2nd ed., pp. 637–648). Toronto, ON: Fitzhenry & Whiteside.

McKinlay, J., & Marceau, L. (2000). US Public Health and the 21st Century: Diabetes Mellitus. *The Lancet, 356*, 757-761.

Miles, B. (2006). *Literature Review: Count Us In! Inclusion and Homeless Women in Downtown East Toronto.* Toronto, ON: Ontario Women's Health Network.

Ministry of Health and Long-Term Care (2007a). OHIP Eligibility. Retrieved July 3, 2007, from http://www.health.gov.on.ca/english/public/pub/ohip/eligibility.html

Ministry of Health and Long-Term Care. (2007b). *Lists of Areas Designated as Underserviced for General/Family Practitioners*. Sudbury, ON: Primary Health Care Team. Retrieved April 14, 2007, from www.health.gov.on.ca/english/providers/program/uap/listof_areas/gp_ladau.pdf

Morgenson, L. (2007, May). Champion of Downtown Kitchener. *Good Work News, 89*, 6–7.

National Housing and Homelessness Network. (2001). State of the Crisis Report: A Report on Housing and Homelessness in Canada. Toronto, ON: Author.

Novac, S., Serge, L., Eberle, M., & Brown, J. (2002). *On her own: Young Women and Homelessness in Canada*. Ottawa, ON: Status of Women Canada.

O'Connell, J.J. (2004). Dying in the Shadows: The Challenge of Providing Health Care for Homeless People. *Canadian Medical Association Journal, 170*, 1251–1252.

Ontario Prevention Clearing House, Ontario Women's Health Network, Toronto Christian Resource Centre, & Toronto Public Health. (2006). *Count Us In! Inclusion and Homeless Women in Downtown East Toronto*. Toronto, ON: Author.

Ontario Women's Health Council. (2002). *Health Status of Homeless Women: An Inventory of Issues*. Toronto, ON: Author.

Pederson, A., & Raphael, D. (2006). Gender, Race and Health Inequalities. In D. Raphael, T. Bryant, & M. Rioux (Eds.), *Staying Alive: Critical Perspectives on Health, Illness and Health Care* (pp. 159 – 192). Toronto, ON: Canadian Scholar's Press.

Plumb, J.D. (2000). Homelessness: Reducing Health Disparities. *Canadian Medical Association Journal, 162*, 172–173.

Polanyi, M. (2004). Understanding and Improving the Health of Work. In D. Raphael (Ed.), *Social Determinants of Health: Canadian Perspectives* (pp. 95-106). Toronto, ON: Canadian Scholar's Press.

Radhika, V (2004). Canada: Homeless in Toronto. *Women's Feature Service*, Retrieved May 30, 2007, from GenderWatch (GW) database. (Document ID: 782493571).

Raphael, D. (2004). Introduction to the Social Determinants of Health. In D. Raphael (Ed.). *Social Determinants of Health: Canadian Perspectives* (pp. 1–18). Toronto ON: Canadian Scholar's Press.

Raphael, D. (2006). Social Determinants of Health: Present Status, Unanswered Questions, and Future Directions. *International Journal of Health Services, 36*, 651–677.

Reaching Our Outdoor Friends. (2007). *About Roof.* Retrieved March 7, 2007, from http://www.roof-agency.net/

Region of Waterloo. (2005). *Region of Waterloo in the 21st century: A Community Action Plan for Housing. Action Plan Highlights #3 – Housing Affordability.* Kitchener, ON: Regional Municipality of Waterloo.

Region of Waterloo, Planning, Housing and Community Services. (2005a). *Housing: Fact Sheet.* Kitchener, ON: Regional Municipality of Waterloo.

Region of Waterloo, Planning, Housing and Community Services. (2005b). *Waterloo Region in the 21st century: A Community Action Plan for Housing.* Kitchener, ON: Regional Municipality of Waterloo.

Region of Waterloo, Social Services. (2003). Waterloo Region Community Homelessness Plan Update. Kitchener, ON: Regional Municipality of Waterloo.

Region of Waterloo, Social Services. (2004). *The Region of Waterloo' s Role in Addressing Homelessness: A Discussion Document.* Kitchener, ON: Regional Municipality of Waterloo.

Reid, C. (2002). *A Full Measure: Towards a Comprehensive Model for the Measurement of Women's Health.* Vancouver, BC: The B.C. Centre of Excellence in Women's Health.

Reid, C., & Tom, A. (2006). Poor Women's Discourses of Legitimacy, Poverty and Health. *Gender & Society, 20* (3), 402-421

Robbins, S.P., & Canda, E.R. (2005). *Contemporary Human Behaviour Theory: A Critical Perspective for Social Work.* Boston, MA: Allyn & Bacon.

Robertson, A. (1998). Shifting Discourses on Health in Canada: From Health Promotion to Population Health. *Health Promotion International, 13*(2), 155–166.

Rossiter, A. (2001). Innocence Lost and Suspicion Found: Do we Educate for or Against Social Work? *Critical Social Work, 2*(1).

Rubin, A., & Babbie, E.R. (2005). *Research Methods for Social Work* (5th ed.). Belmont, CA: Thomson Learning.

Sandercock, L. (1998). The Death of Modernist Planning: Radical Praxis for a Postmodern Age. In M. Douglass & J. Friedmann (Eds.), *Cities for Citizens: Planning and the Rise of Civil Society in a Global Age* (pp. 163–184). London, UK: John Wiley & Sons.

Schram, T.H. (2003). *Conceptualizing Qualitative Inquiry: Mindwork for Fieldwork in Education and the Social Sciences.* Upper Saddle River, NJ: Pearson Education.

Shapcott, M. (2004). Housing. In D. Raphael (Ed.), *Social Determinants of Health: Canadian Perspectives* (pp. 201–215). Toronto, ON: Canadian Scholar's Press.

Shaw, M. (2004). Housing and Public Health. *Annu. Rev. Public Health, 25,* 397–418.

Shragge, E. (2003). *Activism and Social Change: Lessons for Community and Local Organizing.* Peterborough, ON: Broadview Press.

Smith, D.E. (1987). *The Everyday World as Problematic: A Feminist Sociology.* Toronto, ON: University of Toronto Press.

Social Planning Council of Cambridge and North Dumfries. (2006). *Community Trends in Cambridge and North Dumfries*. Cambridge, ON: Author.

Spitzer, D.L. (2005). Engendering Health Disparities. *Canadian Journal of Public Health, 96,* 578.

Stansfield, S.A. (2006). Social Support and Social Cohesion. In M.G. Marmot & R.G. Wilkinson (Eds.), *Social Determinants of Health* (pp. 48-171). Oxford, UK: Oxford University Press.

Street Health. (2006). *Failing the Homeless: Barriers to the Ontario Disability Support Program for Homeless People with Disabilities*. Toronto, ON: Author.

Sussman, D., & Tabi, M. (2004). Minimum Wage Workers. *Perspectives on Labour and Income, 5*(3), 5–14.

Tarasuk, V. (2004). Health Implications of Food Insecurity. In D. Raphael (Ed.), *Social Determinants of Health: Canadian Perspectives* (pp. 187-200). Toronto, ON: Canadian Scholar's Press.

TD Economics (2005). From Welfare to Work in Ontario: Still the Road Less Travelled. Retrieved June 15, 2007, from http://www.td.com/economics/special/welfare05.pdf

Tipple, A.G., & Speak, S.E. (2005). Definitions of Homelessness in Developing Countries. *Habitat International, 29,* 337–352.

Townson, M. (2000). *A Report Card on Women and Poverty*. Ottawa, ON: Canadian Centre for Policy Alternatives. United Nations (2007). *Fact Sheet No.21: The Human Right to Adequate Housing*. Retrieved July 3, 2007, from http://www.unhchr.ch/html/menu6/2/fs21.htm

Vozoris, N.T., & Tarasuk, V.S. (2003). Household Food Insufficiency Is Associated with Poorer Health. *Journal of Nutrition, 133* (1), 120–126.

Waterloo Region Community Homelessness Working Group. (2001). *Waterloo Region Community Homelessness Plan*. Kitchener, ON: Social Planning Council of Kitchener-Waterloo.

Watson, S., & Austerberry, H. (1986). *Housing and Homelessness: A Feminist Perspective*. London: Routledge & Kegan Paul.

Wharf Higgins, J. (1999). Closer to Home: The Case for Experiential Participation in Health Reform. *Canadian Journal of Public Health, 90*(1), 30-34.

Wharf Higgins, J., Young, L., Cunningham, S., & Naylor., P.J. (2006). Out of the Mainstream: Low-Income, Lone Mothers' Life Experiences and Perspectives on Heart Health. *Health Promotion Practice, 7*(2), 221-233.

Whitzman, C. (2006). At the Intersection of Invisibilities: Canadian Women, Homelessness and Health Outside the "Big City." *Gender, Place and Culture, 13*, 383–399.

Wilkinson, R.G. (1996). *Unhealthy Societies: The Afflictions of Inequality*. London, ON: Routledge.

Wilson, S.H., & Walker, G.M. (1993). Unemployment and Health. *Annual Review of Public Health, 107* (3), 153-162.

Wuest, J., Merritt-Gray, M., Berman, H., & Ford-Gilboe, M. (2002). Illuminating Social Determinants of Women's Health using Grounded Theory. *Health Care for Women International, 23*, 794–808.

Young, I.M. (1990). *Justice and the Politics of Difference*. Princeton, NJ: Princeton University Press.